PERCEPTIONS OF EMPLOYERS AND EDUCATORS TOWARD THE IMPORTANCE OF FUNCTIONS OF THE CLINICAL NURSE SPECIALIST

by

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Chapter I

Introduction

The clinical nurse specialist is a relatively new job classification for nurses. The American Nurses' Association defines the clinical nurse specialist as:

> A practitioner holding a master's degree with a concentration in specific areas of clinical nursing. The role of the clinical nurse specialist is defined by the needs of a select client population, the expectations of a larger society, and the clinical expertise of the nurse. By exercising judgement and demonstrating leadership ability, the clinical nurse specialist functions within a field of practice that focuses on the needs of the client system and encompasses interaction with others in the nursing and health care systems serving the client. (Scope of Nursing, 1976)

While the idea of specialization in nursing dates back to the early 1900's, the specific educational preparation for clinical specialization began to be more widely available in the 1950's and 1960's. Most early master's programs in nursing focused upon the functional preparation (i.e., teaching or administration in nursing). In the past ten to twenty years, however, these areas have been deemphasized while clinical expertise has become the focus of most programs.

Master's programs in nursing typically include majors such as Medical Surgical Nursing, Psychiatric/

Mental Health Nursing, Maternal Child Nursing and Community Health Nursing. Often the programs also include some subspecialty majors such as Cardiovascular Nursing, Hematology Nursing, Rehabilitation Nursing and the like. Regardless of the title of major, the student is expected to gain indepth knowledge and skills in assessment of clients in that particular clinical area, and in the planning, implementation and evaluation of nursing care of these clients. The knowledge and skills learned should be at such a level that the graduates of these programs are considered highly skilled in the care of a specific category of client. In addition, the student is to gain beginning research and leadership skills, and a philosophical base for practice.

Acceptance of the clinical nurse specialist role in the Kansas City area has been slow. Miles (1972) cited the lack of a master's program to prepare clinical nurse specialists in the Kansas City area as the major contributor to the lack of understanding and utilization of this new health care practitioner. In 1970 the University of Kansas School of Nursing graduated the first nurses prepared at the master's level in this area. Miles (1972) carried out a small survey of health institutions in the Kansas City area. Miles' questionnaire asked the administrators whether they employed the clinical nurse specialist and if not, would they be interested in hiring

clinical nurse specialists. Of the hospitals (18) and community health agencies (16) which replied, ten hospitals (55%) and eight community health agencies (50%) employed nurses prepared at the master's level. The majority of these 35 nurses were filling clinical or administrative positions. Eighty eight percent of the hospitals responding and 75 percent of the responding community health agencies reported that they would be interested in hiring nurses prepared at the master's level. Both types of agencies reported needing these nurses to fill primarily clinical positions.

As graduates of master's programs have demonstrated their expertise in client care, and as the supply in the Kansas City area has increased, the number of positions for clinical nurse specialists has grown. Each week in the Kansas City area health institutions advertise for clinical nurse specialists. No studies of the number of clinical nurse specialists employed or available clinical nurse specialist positions have been discovered in the literature. However, from the reports of graduates of the master's program and requests from health institutions to post job vacancy notices, it is apparent that acceptance of and/or the need for this type of health professional is steadily growing. A 1978 survey of graduates of the University of Kansas Master of Nursing Program showed that 25 percent of the graduates were

holding clinical nurse specialist positions (Duffey & Clifford, 1978). This was particularly significant when one considers that the University of Kansas Master of Nursing Program was less than ten years old at the time of the survey. In newly developed programs, the vast majority of students are educators who are pursuing the master's degree in order to gain the credentials to remain in teaching positions. The initial influx into the University of Kansas graduate program of nurses interested in receiving preparation to teach has abated; more prospective students indicate intentions to pursue solely clinical specialist preparation. This trend of increasing interest in preparation for clinical nurse specialization is a national movement. In 1964-65 13.6 percent of graduates of master's programs indicated advanced clinical practice as their major area of study. In 1974-75 this percentage had increased to 56.9. (HEW, 1978)

Since the first master's programs in nursing, nursing educators have been concerned with evaluation of these programs. Nursing educators have progressed in the development of program evaluation designs in a manner similar to other educational evaluators (Popham, 1975; Vacek & Ashikaga, 1978). Specifically, most evaluation attempts have initially focused upon student and faculty opinion of specific courses and the total curriculum, and

the graduates' opinions of the program's effectiveness. Any attempts at revision of the programs have been based upon these results as well as upon evolution of nursing educators' ideas of the necessary content areas for graduate education in nursing.

Since master's programs in nursing are preparing graduates to be employed in nursing, it follows that the expectations of potential employers should be considered in any program evaluation. Reports of such systematic considerations of employers expectations in evaluation of master's programs in nursing cannot be found in the literature. Although the literature is filled with narrative accounts of how the clinical nurse specialist should be expected to perform, the majority of these are written by nursing educators or clinical nurse specialists rather than by employers.

Need for the Study

This study evolved from the interest and participation of the investigator in an ongoing evaluation project for the Master of Nursing Program at the University of Kansas. The need to involve employer feedback in the evaluation scheme was recognized. In reviewing Stufflebeam's framework (1971, 1973) for educational evaluation, it became clear that employer feedback could be used in both "context" and "product" evaluation. In some graduate programs in nursing, there are efforts currently

underway to use employer feedback in the product evaluations. However, no evidence can be found of the use of employer expectations as one basis for determination or revision of objectives of master's programs in nursing (context evaluation). Since the educators of clinical nurse specialists are responsible for the development of the objectives of the educational programs, their expectations should also be considered. A logical starting point for this effort seemed to be the determination of similarities and differences in the expectations of educators and employers as to the relative importance of specific functions of the clinical nurse specialist.

Only one study could be located which focused on the identification of core competencies of graduates of master's programs in nursing (McLane, 1975, 1978). In that study, the basis for the development of the instrument used to identify the core competencies was a literature review and interaction of the investigator with a panel of experts which included only one director of nursing service. Further, this study did not identify expected functions of clinical nurse specialists.

Therefore, there was a need for development of an inventory with which evaluators of master's programs in nursing could determine the perceptions of employers and educators of clinical nurse specialists. The identification of similarities and differences in expectations

of the clinical nurse specialist could form the basis for a review and possible revision of objectives of master's programs in nursing in the Midwest.

Theoretical Framework for Educational Evaluation

Stufflebeam's Decision-Oriented Model

After a review of the major models for educational evaluation (See Chapter II, Educational Evaluation), the Stufflebeam model was chosen as the one most appropriate to the study. Since this dissertation is one part of an ongoing evaluation project of the master's program in nursing at the University of Kansas, a framework which could include all parts of that project was necessary. The Stufflebeam model fit this need. In order to understand the rationale for use of this model, a brief examination is necessary.

The definition of evaluation in the Stufflebeam model is "evaluation is the process of delineating, obtaining and providing useful information for judging decision alternatives" (Stufflebeam, 1971, p. 40). In an address at a Phi Delta Kappa symposium, Stufflebeam listed four key points which were important to the understanding of the model. These were:

1. The purpose of evaluation is to aid decision makers; therefore, the information should be useful.

2. Because evaluation is an ongoing cyclic process, it should be orderly and systematic.

3. The bases for the methodology are the steps of delineating, obtaining and providing.

4. The delineating and providing steps must be done in cooperation with the decision maker; the obtaining is the province of the evaluator (Stufflebeam, 1973).

There are three major parts to the Stufflebeam model. These are decision settings, decision types and evaluation types. Decision settings differentiate among the settings in which decisions are made. Decision settings where the purpose is maintenance of the system are called homeostatic. Incremental is the term given to the decision setting where the purpose is continuous improvement. Neomobilistic settings are those in which the purpose is development of innovative solutions to large, important problems in education. Metamorphic settings involve utopian efforts to completely change an educational system. The evaluation project for the master's program and for this dissertation meet the criteria for the incremental decision setting (Popham, 1975; Stufflebeam, 1971; Stufflebeam, 1973).

Stufflebeam describes four types of decisions. These are "planning decisions to determine objectives, structuring decisions to design procedures, implementing decisions to utilize control and refine procedures, and recycling decisions to judge and react to attainments" (Stufflebeam, 1973, p. 135). The evaluation project

for the master's program in nursing at the University of Kansas is concerned with each of these types of decisions. This dissertation is concerned with the planning decision type only.

For each of the categories of decisions, Stufflebeam has identified a type of evaluation. These are 1) contextual evaluation, (2) input evaluation, (3) process evaluation, and (4) product evaluation. Extensive descriptions of each of these types appears in Stufflebeam's (1971) writings. For the purposes of this investigation, it is enough to understand the basic purpose of each kind of evaluation. In context evaluation, the purpose is to provide the rationale for the identification of objectives. Input evaluation is to provide information for decisions about how to employ the resources to reach the goals. Process evaluation is used in the ongoing program to detect defects in the program implementation, to assist in preprogrammed decisions and to keep a comprehensive record of the actual functioning of the program. Product evaluation should be used at the end of the project cycle and on an ad hoc basis during the project (Gardner, 1977; Popham, 1975; Stufflebeam, 1971; Stufflebeam, 1973). This dissertation is an example of the data gathering process necessary for contextual evaluation. Although the objectives for the master's program in nursing at the University of Kansas were

determined prior to the curriculum evaluation project, a reexamination of the objectives is called for by the cyclic nature of Stufflebeam's model. This investigation is one preliminary step for that reexamination.

In summary, the reasons for choosing the Stufflebeam model were twofold. First, a model was needed in which the emphasis was placed upon the provision of information by the evaluator for the use of the decision makers. Secondly, the Stufflebeam model provided for the periodic review of the needs of a particular segment of society in order to reevaluate program objectives. This dissertation is a specific example of an educational effort directed toward that end.

The Problem

The purpose of this study is to determine the similarities and differences between the perceptions of employers and educators of clinical nurse specialists. Specifically, do the educators and employers of clinical nurse specialists perceive the relative importance of specific functions of the clinical nurse specialist alike or differently? Secondly, do the employers and educators of clinical nurse specialists perceive the importance of four components of the role of the clinical nurse specialist alike or differently? These role components are (1) the clinical component, (2) the education component, (3) the administration component, and (4) the research

component. Finally, is there any discernable relationship between the various biographical and institutional characteristics of the respondents and their perceptions of the relative importance of specific functions of the clinical nurse specialist.

The general hypotheses, stated in the null, are:

1. There are no significant differences between employers and educators in their responses of perceived importance of each of the 37 functions on the Clinical Nurse Specialist Functions Inventory.

2. There are no significant differences between the employers' and educators' of clinical nurse specialists perceptions of the importance of the four components of the clinical nurse specialist role, i.e., the clinical component (items 1-11), the education component (items 12-20), the administration component (items 21-29), and the research component (items 30-37) in the Clinical Nurse Specialist Functions Inventory.

A set of contingency tables was developed for each biographical and institutional variable and each of the 37 items on the Clinical Nurse Specialist Functions Inventory. These tables were inspected to identify possible relationships between the biographical and institutional variables and the perceptions of importance of the 37 functions of the clinical nurse specialist.

Summary of Procedures Followed in this Investigation

Two groups were surveyed. First, using a computer list of random numbers, a sample of graduate faculty of National League for Nursing accredited master in nursing programs in 11 Midwestern states was chosen. Next, nursing service administrators in hospitals with more than 200 beds and health agencies located in a city of above 100,000 population or in a university town were randomly selected. The specifications of case load size and population were necessary in order to increase the likelihood of a clinical nurse specialist being employed in these institutions. The two groups were asked to respond to the 37 item Clinical Nurse Specialist Functions Inventory (CNSFI). This inventory collected information regarding four factors. These factors were: (1) clinical, (2) education, (3) administration, and (4) research; each factor measures a component of the role of the clinical nurse specialist. All respondents were also asked to provide biographical and institutional information.

The data were analyzed using the Statistical Package for Social Sciences (SPSS) (Nie, N. H., Hull, C. H., Jenkins, J. G., Steinbrenner, K. & Brent, D., 1975) frequencies, t-test and crosstabs programs.

Limitations of the Study

All inferences from this study must be limited to the educators and employers of clinical nurse specialists

in 11 Midwestern states. In addition, no inferences can be made about expected functions of other master's prepared nurses such as teachers or administrators.

Definitions

> Clinical Nurse Specialist: A practitioner holding a master's degree with a concentration in specific areas of clinical nursing. The role of the clinical nurse specialist is defined by the needs of a select client population, the expectations of the larger society, and the clinical expertise of the nurse. By exercising judgement and demonstrating leadership ability, the clinical nurse specialist functions within a field of practice that focuses on the needs of the client system and encompasses interaction with others in the nursing and health care systems serving the client. (Scope of Nursing, 1976)

NLN Accredited Master's Program in Nursing: An educational program in a college or university designed to prepare nurses for advanced positions in clinical, administrative, or educational areas and for which the master's degree is awarded upon completion. This program shall have officially received accredited status from the National League for Nursing.

Educator: A graduate faculty member of a National League for Nursing accredited master's program in nursing who is a nurse and teaches graduate nursing students.

Employer: The chief administrative officer in nursing service or designee who is responsible for employment decisions regarding clinical nurse specialist positions in hospitals or health agencies.

Function: A specific act of the clinical nurse

specialist directed toward clinical, education, administration or research activities in nursing.

Functional Area Major: A term used by the nursing profession to denote an academic major in clinical specialization, education, administration or research.

Components of Clinical Nurse Specialist Role: A set of job functions of the clinical nurse specialist which are directed toward one specific category of functions, i.e., clinical, education, administration and research.

Summary

The role of the clinical nurse specialist is relatively new and the educational programs preparing these nurses are also new. Few efforts to determine the employer's expectations of the clinical nurse specialist are found in the literature. Because of the need to educate the clinical nurse specialist to meet the needs of the employer for delivery of health care services, it was important to discover the similarities and differences of perceptions of the employers and educators of clinical nurse specialists. Specifically, what are the differences and similarities in perceptions of these two groups in regard to the relative importance of 37 specific functions of the clinical nurse specialist and the importance of four specific components of the clinical nurse specialist role? These components are clinical, education, administration and research.

An instrument was developed by the investigator to measure the educators' and employers' perceptions of importance of these 37 functions and four clinical nurse specialist role components. This instrument, the Clinical Nurse Specialist Functions Inventory, was administered to educators and employers of clinical nurse specialists in an 11 state area of the Midwest. Two hypotheses were tested using the t-test for independent means. Other results were obtained by inspection of contingency tables and ranking of the functions of the clinical nurse specialist according to mean scores of educators and employers.

Chapter II

Review of Literature

The review of relevant literature to the stated problem is divided into three sections. These are "Master's Education in Nursing," "Clinical Nurse Specialist" and "Educational Evaluation." The sections on Master's Education in Nursing and the Clinical Nurse Specialist are designed to give the reader a historical orientation as well as to provide insight into the current thinking of nursing educators, practitioners and administrators regarding each area. The section on Educational Evaluation is designed to provide a theoretical framework for this dissertation.

Master's Education in Nursing

Nursing is a very old profession; however, the history of its formal educational structure is quite short. Institutionalized nursing was originally a nurturing art performed by monks or nuns who received no formal training. The first school for the training of nursing was founded in England in the 19th century. This school was affiliated with a hospital and afforded apprentice-like training to young women. The majority of nursing schools followed a modification of this pattern

of apprentice training in hospitals until the 1960's. Today the trend is toward the basic education of nurses taking place in the community college, college or university setting.

The Bachelor of Science in Nursing programs were sufficiently numerous that, in 1935, the Association of Collegiate Schools of Nursing was formed (Bullough & Bullough, 1964). Also, by this time, many undergraduate collegiate programs had developed to prepare the nurse for teaching or administrative functions. As the number of these undergraduate programs which focused upon clinical nursing grew, the National League for Nursing (NLN) began to upgrade its standards for collegiate nursing programs. In 1949, according to the "Study of Nursing Schools in the Mid-Century" written by West and Hawkins (1950), only 55 percent of all the nursing instructors held academic degrees. In 1960, however, over 76 percent of faculty in hospital programs and 99 percent of faculty in collegiate programs had at least the bachelor's degree (Bullough & Bullough, 1964).

In order to meet the demands for more highly prepared faculty for both the hospital and collegiate schools, many nurses were turning to graduate study. Although graduate education in nursing had been available since at least 1932, it was quite similar to many collegiate bachelor's programs until the mid-50's. In

1952, the NLN called a conference to set forth the basis for differentiating master's programs from bachelor's programs in nursing. They determined that the bachelor's degree programs should focus on the preparation of the generalized professional nurse while the master's program should focus on preparation of the educator, administrator and advanced clinical specialist (Bullough & Bullough, 1964).

Because of the great need for teachers and administrators of nursing, most early master's programs focused upon these two areas. However, in the patient care setting, it seemed that the more degrees a nurse held, the more removed she/he became from the patient. Many nurses were dissatisfied with this situation, and practitioners and educators began to look at the third option spelled out in the 1952 NLN conference, that of master's degree preparation for advanced clinical specialization. With the continual advances in medicine and nursing, and a better understanding of the physiological and psychological components of health and illness required for adequate patient care, it could be asserted that the nurse with the most education should be closer to patient care, not further away (Bullough & Bullough, 1964). Therefore, master's programs with clinical specialist options began to develop more rapidly. In 1972, Grossman reported that out of 57 master's programs, 27 (47%)

allowed the student to major in a clinical area without enrolling in functional courses. Today, of the 80 NLN accredited master's programs in nursing, 67 (84%) provide opportunities for students to graduate without functional area courses in teaching or administration (Master's Education in Nursing, 1979).

The National League for Nursing, in a publication titled Characteristics of Graduate Education in Nursing Leading to the Master's Degree (1979), indicated that graduate education in nursing provides students the opportunity to

> (1) acquire advanced knowledge from the sciences and the humanities to support advanced nursing practice and role development; (2) expand their knowledge of nursing theory as a basis for advanced nursing practice; (3) develop expertise in a specialized area of clinical nursing practice; (4) acquire the knowledge and skills related to a specific functional role in nursing; (5) acquire initial competence in conducting research; (6) plan and initiate change in the health care system; (7) further develop and implement leadership strategies for the betterment of health care; (8) actively engage in collaborative relationships with others for the purpose of improving health care; and (9) acquire a foundation for doctoral study. (Graduate Education, 1979, p. 1)

It is evident that the NLN has broadened the definition of functional area majors to include preparation for the clinical specialist role also. Indeed, they say,

> The relationship between clinical and functional preparation is of critical importance. Although advanced clinical preparation is at the base of master's preparation in nursing, it alone is not enough. Functional preparation at the master's

> level may focus on such areas as the role of the specialist, teacher or administrator. (Graduate Education, 1979, p. 2)

The Role of the Clinical Nurse Specialist

Specialization in nursing has been a recognized concept in nursing for more than 70 years and has had several meanings. Smoyak (1976) outlines an historical pattern evident in the development of clinical specialization as it exists today. Initially, specialization in any field starts with the "first one." These individuals have no formal teachers or role models. They establish their own standards. Secondly, the next generation of specialists learn from the "master" in an apprenctice-like fashion. Next, this may expand in future generations to involve small groups of students learning from the pioneer, as disciples from the master. Finally, the several disadvantages in this method (cost, parochialism, trial and error method of discovery) eventually result in the teacher and the learner moving into the academic setting. There "learning is organized, systematized and greatly enhanced by access to libraries and reference sources, where people engaged in similar pursuits are available for dialogue, and where the possibility exists for continuous validation and refinement" (Smoyak, 1976, p. 676). Clinical specialization in nursing has followed this pattern of development.

The private duty nurse, the office nurse and the staff nurse working in a particular clinical area are all early examples of specialization. Today, the idea of clinical nurse specialist connotes expanded knowledge and highly developed expertise in a specifically defined area.

Peplau (1973) in an early article on the clinical nurse specialist identified several societal trends which led to the current concept of specialization in nursing. First, any increase in knowledge about a concept or part of a particular field leads to specialization. The existing educational programs cannot expand to include all basic and new knowledge in a field. Therefore, offshoots or specialities develop. Secondly, new knowledge in the sciences leads to new technologies and, therefore, to the need for new and more complicated skills (intellectual and technological) on the part of practitioners. Thirdly, specialization tends to develop from public interest or needs. Peplau lists rehabilitation and mental retardation nursing as two examples. Two other trends which stimulate the development of clinical specialization in nursing are the efforts of innovators in nursing, and funds made available because of governmental and/or private grants.

Early authors showed little agreement on the specific expectations and functions of the clinical nurse

specialist (Baker & Kramer, 1970; Bruce, 1971; Georgopoulos & Christman, 1970; Peplau, 1973). Indeed, most of the functions identified were taken from statements of opinion rather than from studies based on actual experiences of or with the clinical nurse specialist. Georgopoulos and Christman (1971) state: "the potential of nurse specialist. . . remains unknown and unrealized, for their use in hospital settings to date has been very infrequent and limited" (p. 1030). Bruce (1971) underscores this by stating that "there are no published reports available indicating understanding, agreement or acceptance of the functions of the clinical nurse specialist role" (p. 56). The roles identified by one or more of these authors are (1) expert practitioner and model, (2) teacher, (3) change agent, (4) coordinator, (5) researcher, (6) counselor, (7) supervisor, (8) manager, (9) standard bearer for nursing, (10) consultant, (11) trouble shooter, (12) evaluator, (13) leader in nursing, and (14) community worker.

The roles of the clinical nurse specialist which seem to be most prevalent in the literature are those of expert practitioner, teacher, change agent, researcher and consultant (Woodrow & Bell, 1971). The idea of the provision of direct patient care seems to be a universal continuing theme in clinical nurse specialist literature. (Christman, 1973; Peplau, 1973; McMullan, 1977; Crabtree,

1979). The clinical nurse specialist's education is directed toward preparation to provide expert nursing care to a specific category of patient or to persons with a specific kind of disease process or health need. The critical care clinical nurse specialist (Morris & Schweiger, 1979), the tuberculosis clinical nurse specialist (Little & Carnevali, 1967), the psychiatric nurse therapist (Davidson et al., 1978), the pediatric clinical nurse specialist, the oncology clinical nurse specialist, the women's care clinical nurse specialist, the cardiovascular clinical nurse specialist ("Characteristics of Graduate Education", 1979) are all examples of the variety of special categories of health needs or kinds of patients for which the clinical nurse specialist is able to provide specialized nursing care. In-depth knowledge in the sciences basic to the understanding of human behavior, normal and abnormal physical states, and the skills of observation and manipulation necessary to diagnose and intervene in health care situations are the primary areas covered in the clinical nurse specialist educational programs today (McMullan, 1977). By virtue of the definition of the clinical nurse specialist accepted by the American Nurses' Association (1976), it is evident that the clinical role (provision of direct or indirect nursing care) is the paramount feature of the clinical nurse specialist position.

The teacher role is probably the next most frequent role for the clinical nurse specialist to perform. The teacher role can be fulfilled by formal teaching activities (lecturer, discussion leader, clinical supervisor for nursing students, and patient teaching) or informal activities (role model). The clinical nurse specialist should have as a goal the advancement of quality health care through the education of other health professionals, students, patients, families and the public. (Bruce, 1971; McGann, 1975; Feutz & Jackson, 1979; Morris & Schweiger, 1979).

The consultant role is closely aligned with the teacher role. Several authors, however, single out this role for special consideration. (Goldstein, 1979; Blake, 1977; McGann, 1975; Feutz & Jackson, 1979). Blake (1977) identifies the consultant role as an "interpersonal, educational process in which the consultant collaborates with a person or group of persons who influence and/or participate in health care delivery and who have requested assistance in problem solving" (p. 33). The relationship is based on the consultee's perceived need for assistance and the consultant's special clinical knowledge and skill. The characteristics which separate consultation from the more general educational role are (1) focus on a specific existing problem and (2) that the consultee has the complete responsibility for determining

whether to utilize the advice.

The change agent role is concerned with innovation in health care. The change agent stimulates others, implements new programs, develops new approaches to health issues, develops new tools to improve and measure patient care, and participates in developing policies and institutional goals which affect health care. In summary the change agent facilitates planned change. (Bruce, 1971; Feutz & Jackson, 1979; Girouard, 1978; McGann, 1975; Silver, 1973).

Researcher is a role for the clinical nurse specialist which is identified by many authors. The testing of nursing theories in practice, helping others in identifying appropriate research questions, carrying out research projects, and implementing research individually or collaboratively, are examples of activities related to research. Almost all authors who deal with roles of the clinical nurse specialist agree that clinical nurse specialist research usually deals with specific patient care problems. (Bruce, 1971; Georgopoulos & Christman, 1970; Feutz & Jackson, 1979; McGann, 1975) The research role is identified by these authors as a small portion of the clinical nurse specialist's responsibilities, yet an important one. However, from the clinical nurse specialist's job descriptions gathered by Duffey and Clifford (1977), it is apparent that not

all employers agree with the idea of the clinical nurse specialist engaging in research. Indeed, of the fourteen clinical nurse specialist's job descriptions submitted, only four included any mention of research.

In most literature about the clinical nurse specialist, the administrative role is not included as a clinical nurse specialist's responsibility. Administrative duties are usually defined as any duties related to the direct supervision or authority over other nurses in the clinical setting. Many authors specifically exclude this role, stating that any administrative duties would interfere with the successful completion of the clinical nurse specialist's primary roles. (Barrett, 1971; Little & Carnevali, 1967; Kirkman & Miller, 1972; McGann, 1975; Towner, 1968). However, administrative duties were included in each clinical nurse specialist's job description received from employers in the Duffey and Clifford survey (1978). Crabtree (1979), Odello (1973), Parkis (1974), and Woodrow and Bell (1971) encourage the role of administrator as a characteristic of the clinical nurse specialist's duties. Formal authority and reward power are thought to assist the clinical nurse specialist in bringing about the necessary maintenance and improvement of high quality patient care. This authority can be the impetus necessary to initiate new programs and to provide an environment to facilitate change.

From 1970 to the present, the literature (as discussed earlier) tends to focus upon descriptions of specific parts of the clinical nurse specialist's responsibilities which are opinions or personal experiences as opposed to research on clinical nurse specialist roles. (Barrett, 1971; Blake, 1977; Crabtree, 1979; Dilworth, 1970; Disch, 1978; Feutz & Jackson, 1979; Goldstein, 1979; Morris & Schweiger, 1979; Murphy & Schmitz, 1979; O'Dello, 1973; Padilla & Padilla, 1979; Parkis, 1974; Piazza & Jackson, 1978; Silver, 1973; Smoyak, 1976; Woodrow & Bell, 1971).

The research done on the clinical nurse specialist is sparse. Three studies were identified which dealt with the development of the clinical nurse specialist role. Baker (1973) interviewed four clinical nurse specialists asking them to recall the process of their role development. They identified four developmental phases - orientation, frustration, implementation and reassessment. Georgopoulos and Christman (1970) introduced a clinical nurse specialist into a medical surgical unit and for 13 months studied the development of the role as well as some effects of this role. This article describes the process of developing a role model for the clinical nurse specialist. A very detailed role model was developed which included the following categories: (1) training and preparation for clinical

practice; (2) professional values and orientation; (3) core functions and activities of the clinical nurse specialist; (4) relevant rights and obligations for incumbents; and (5) work relationships with others at the patient unit. Madden, David and Gifford (1971) described the development of the liaison nurse roles. The functions were identified as assessment, care coordination, follow-through and counseling.

Five studies were found which deal with the testing of the effects of the clinical nurse specialist on patient care. Ayres (1971) studied the effects of the clinical nurse specialist on the improvement of staff nurses' ability to define major clinical/patient problems as tested by the Nursing Problems Priority Inventory. The staff nurse on units with a clinical nurse specialist experienced more improvement in identification of problems than staff nurses on units with no clinical nurse specialist. Georgopoulos and Jackson (1970) hypothesized that the quality and quantity of nursing information in the Kardex Nursing Care Plan would improve in units led by a clinical nurse specialist as opposed to the traditional head nurse. This hypothesis was supported. Georgopoulos and Sara (1971) tested a similar hypothesis related to the change of shift report. This hypothesis was also supported. The effect of the clinical nurse specialist on specific behavioral and physiological

variables of tuberculosis patients was studied by Little and Carnevali (1967). The study found few positive effects for the patients who were cared for by the clinical nurse specialist. Murphy (1971) had similar findings in her study to determine if pre and post operative nursing care by a clinical nurse specialist could affect the (1) frequency of complications, (2) the rate of progress and (3) the patient's perception of hospitalization and nursing care. There was no difference in any of the areas when the care was given by a clinical nurse specialist and by a regular staff nurse.

Two other research studies relate to the clinical nurse specialist as a change agent and employment opportunities for the clinical nurse specialist. The availability of a clinical nurse specialist using a strategy of planned change significantly increased the staff nurses' implementaion of pre-operative teaching (Girouard, 1978). Miles (1972) surveyed the Kansas City area hospitals, community health agencies and schools of nursing. She determined that the majority of all of these agencies employed clinical nurse specialists and many of those that did not employ them were interested in doing so in the future.

The only study to deal with the assessment of the importance of functions of the clinical nurse specialist was undertaken by Bruce (1971) in Boston. She surveyed

139 nurses (53 nursing service administrators, 24 educators, 12 clinical nurse specialists and 46 practicing nurses) as to the value of certain functions of the clinical nurse specialist. The roles Bruce identified were: (1) practitioner of nursing, (2) researcher, (3) change agent, and (4) educator.

In general, even in this limited early study the four groups did not agree among themselves on the valuation of the functions identified by Bruce in any systematic fashion. Educators and nursing administrators placed most importance on the educator-practitioner functions. Research functions were viewed as somewhat important and the change agent functions were seen as not important. The clinical nurse specialist group rated the educator-practitioner functions highest, then the change agent functions and lastly the research functions. The practicing nurses valued the change agent functions and educator functions highly while the practitioner functions were valued at a lower level and research functions at an even lower level. As Bruce recommended, there seemed to be a need to undertake a larger study to identify the roles of the clinical nurse specialist and to determine the importance of functions of the clinical nurse specialist within their roles. The latter is the intent of this study.

Educational Evaluation

Evaluation is directed at determining the value or merit of an entity. Educators have been evaluating for as long as the profession has existed; however, most of the efforts have been directed at evaluating students and perhaps instructional methods, textbooks and the like (Popham, 1975). Only recently, in the 1960's and 1970's, have there been concerted efforts to develop evaluative theory and techniques to the point where a subspecialty of educational evaluation has evolved. Popham (1975) and others list societal forces which have encouraged or demanded this development. These societal forces according to Popham (1975) are: (1) dissatisfaction with public education, (2) federal education dollars, (3) shrinking financial support, and (4) decentralization. Others speak of the accountability crisis (in which they include the factors discussed by Popham) as the major impetus for the development of educational evaluation as a subspecialty of education (Anderson, Ball, Murphy & Assoc., 1975; Gardner, 1977).

Since educational evaluation has developed into a distinct area, many writers have expended considerable effort distinguishing between research and evaluation (Anderson et al., 1977; Dressel, 1976; Oetting, 1976; Popham, 1974, 1975; Stufflebeam, 1971; Worthen & Saunders, 1973). Although research and evaluation may

use similar methods, different methods or different criteria for selection of methods may be used. Many authors have developed exhaustive lists of similarities and differences. However, for the purposes of this dissertation, it is sufficient to say that the major difference between research and evaluation is in the purpose. All other differences flow from that. The purpose of research is to acquire new knowledge. The purpose of evaluation is to acquire specific knowledge in order to judge merit and/or make decisions.

With the concentration on evaluation, several models for educational evaluation have emerged. A few educators have proposed frameworks for examining these models. Gardner (1977) and Popham (1975) have each developed such frameworks. Gardner's (1977) framework divides educational evaluation models into five categories. These categories include: (1) evaluation as professional judgment, (2) evaluation as measurement, (3) evaluation as the assessment of congruence between performance and objectives, (4) decision-oriented evaluation and (5) goal free/responsive evaluation. Popham's (1975) framework identifies four categories for educational evaluation models. His categories are: (1) goal attainment models, (2) judgmental models emphasizing intrinsic criteria, (3) judgmental models emphasizing extrinsic criteria and (4) decision facilitation models. There are many

similarities between these two frameworks, but for the purposes of clarity, the various models will be discussed here using Gardner's framework.

Each category in Gardner's framework is delineated by a different definition of evaluation which expands upon the dictionary definition of "the determination of value or worth" (Random House, 1978). Gardner's first category title is essentially the evaluation definition for that category. In the evaluation as professional judgment category, an expert in a field is asked to examine the entity to be evaluated. The judgment by this expert as to the value of the entity is the evaluation. Accrediting team judgments, peer review panels, referees for judging manuscripts and the like are examples of this type of evaluation. The focus here is on the expert judges.

The definition for evaluation used in the evaluation as measurement category is "the measurement of results, effects or performance using some type of formalized instrument which produces data that can be compared to some sort of standardized scale" (Gardner, 1977, p. 575). Examples of this type of evaluation are the use of the Graduate Record Exam or the Scholastic Aptitude Test to predict academic aptitude. The focus in this category is on the data and the instruments.

Gardner, in his third category assessment of congruence between performance and objectives, defines evaluation as "the process of specifying or identifying goals, objectives or standards of performance; identifying or developing tools to measure performance and comparing the measurement data collected with the previously identified objectives or standards to determine the degree of discrepancy or congruence which exists" (Gardner, 1977, p. 577). These evaluation efforts may be formative (done during the ongoing project) or summative (done after completion of the project) (Scriven, 1973). They may be as simple as pretest-treatment-posttest or as complex as a multifactor evaluation of a large educational project. Malcolm Provus, Robert Satke and Michael Scriven are the major theorists in this type of evaluation. Although their models differ from each other in many ways, they are similar in that the major focus of each model is upon the objectives and the attainment of these objectives using extrinsic criteria (Popham, 1975; Gardner, 1977).

Decision-oriented evaluation is exemplified by two major models, the Stufflebeam model and the Alkin model. The Stufflebeam definition of evaluation is "the process of delineating, obtaining and providing useful information for judging decision alternatives" (Stufflebeam, 1971, p. 40). The Alkin definition describes evaluation as "the process of ascertaining the decision areas of

concern, selecting appropriate information, and collecting and analyzing information in order to report summary data useful to decision-makers in selecting among alternatives" (Alkin, 1972, p. 107). These models provide an institutionalized system for continuous feedback. Popham (1975) asserts that although these models may be similar to models in other categories, their focus is upon the decision needs for an entire educational project and upon providing information to the decision makers, not any judgments of merit by the evaluators themselves. Packaged systems such as the Western Interstate Commission for Higher Education Costing and Data Management System are available which are based upon the decision making models although the Stufflebeam model emphasizes maximum flexibility. The focus of these models is upon the continuous provision of appropriate information for the decision makers.

Gardner's last category, goal-free/responsive evaluation, has been recently added to the evaluation concept. Goal-free evaluation has been developed by Scriven while responsive evaluation was proposed by Stake. While the specifics of these models differ somewhat, their major focus is on obtaining all information about the effects of a project irrespective of the goals of that project. They have therefore expanded their definitions of evaluation to include

assessment of any outcome whether intended or unintended (Gardner, 1977).

Chapter III

METHODOLOGY

The Design of the Study

It was the purpose of this study to investigate the similarities and differences between educators and employers of clinical nurse specialists in reference to their perceptions of the importance of specific job functions of clinical nurse specialists. Secondly, the employers' and educators' perceptions of the importance of the four components of the role of the clinical nurse specialist were investigated as well as the relationship between biographical and institutional variables and perceptions of the importance of the specific functions. The educators and employers were asked to respond to the Clinical Nurse Specialist Functions Inventory (CNSFI) developed by the writer.

This study is an example of survey research as described by Kerlinger (1979). He suggests that survey research is a method by which large and small populations are studied "to discover the relative incidence, distribution and interrelations of sociological and psychological variables" (Kerlinger, 1979, p. 151). Survey research is used primarily in social scientific research

to determine what exists and how it exists in groups, geographic and political areas, or even in nations. One of its main characteristics is its ability to provide correct information on large populations using relatively small samples, (Kerlinger, 1979). Polit and Hungler (1978) describe several purposes of survey research. The first purpose, description, gives the researcher information about the sample's characteristics, attitudes or beliefs so that the distribution of these properties in the population can be determined. Explanation, the second purpose of survey research, is the determination of why people believe certain things or act in certain ways. For this purpose, the researcher studies the relationships among variables. The third purpose specified by Polit and Hungler, prediction, deals with the attempt to predict future outcomes. Political polls, childbearing intention surveys, and health need projections are examples of surveys which fulfill the prediction purpose. Exploration is the final purpose described. In this area, surveys provide overview information regarding an area about which little is known. This is useful in both shaping an appropriate design for study of the area and to suggest hypotheses which may be tested more rigorously in the future. This study has aspects of all these purposes except prediction.

One critical aspect of survey research is the

appropriate selection of the sample to be studied. Kerlinger (1979) and Polit and Hungler (1978) indicate the importance of the representative sample. If a sample is representative, one can say that the results can be generalized to the entire population. They suggest that one of the best ways to assure representativeness is through random sampling.

The major advantages of survey research are the flexibility and comprehensiveness of scope. There are, however, several disadvantages which every researcher must take into account. First, the information received by survey method is usually rather superficial. Secondly, this type of research data does not allow the researcher to be able to determine cause and effect relationships because the researcher is not able to control variables as in an experimental study. Thirdly, survey research can be costly, in terms of personnel and other resources. Since the purpose of this study was to gain general information about a subject which had not been studied extensively and the geographical area to be covered was large, the survey was determined to be an appropriate method.

Instrument Development

Identification of Items

The Clinical Nurse Specialist Functions Inventory (CNSFI) was developed by the investigator. In 1977 a

survey of 107 health agencies was undertaken to determine how many job descriptions existed in these agencies which specified master's degree in nursing as a criterion for eligibility for that position (Duffey & Clifford, 1977). Of the 100 agencies responding, 39 sent 92 job descriptions which specified master's in nursing. Fourteen of these job descriptions were for clinical nurse specialist positions while 52 were for educator positions and 26 were for nursing service administration positions.

All of the function statements on the 14 clinical nurse specialist job descriptions were analyzed and five categories were identified (i.e, clinical, educational, administrative, research, personal development, and other). Then within each category, similar function statements were combined until a representative job description for the clinical nurse specialist resulted. This representative job description included statements which reflected each distinct function and attribute from the 14 job descriptions, with an indication of how often that particular function or attribute appeared in the 14 job descriptions (see Appendix A).

From this representative job description, plus consultation with clinical nurse specialists and the nursing literature on clinical nurse specialists, a working draft of the Clinical Nurse Specialist Functions Inventory was developed. This working draft included four specific

components of the clinical nurse specialist role (i.e., clinical, education, administration and research). The categories of personal development and other were discarded because many of the items seemed to be of a more personal nature and less directly related to the functions of the clinical nurse specialist role. Thirty six items were developed. Each item described a function which was a part of one of the four components of the clinical nurse specialist role identified. A Likert-type scale was used through which respondents could indicate their perceptions of importance of this function (i.e., 4 = utmost importance, 3 = very important, 2 = important and 1 = slightly important.) Selection of 0 indicated the function was not expected as a part of the clinical nurse specialist role.

Since certain biographical and demographic information about the respondents and their agencies was of interest, a set of questions for educators and a set for employers were developed to identify such variables as rank, length of experience with either graduate teaching or nursing administration, educational background, size of agency, geographical region and the like (see Appendix B for Clinical Nurse Specialist Functions Inventory for Educators; see Appendix C for Clinical Nurse Specialist Functions Inventory for Employers).

Validation of Instrument

Validity is an important characteristic of any instrument. It is defined by Kerlinger (1979) and Polit and Hungler (1978) as the ability of an instrument to measure what it is intended to measure. Validity is a very complex issue and certain types are only recently being addressed by researchers. There are several types of validity, i.e., predictive or criterion-related validity (how successfully an instrument predicts to a criterion); content validity (how well the instrument measures the content area intended); and construct validity (determining the underlying attributes or psychological or other properties the instrument measures).

This study was an effort to look at the perceptions of employers and educators of clinical nurse specialist job functions. It can be viewed as a pilot study. Because of this beginning nature and the limited resources of the researcher, it was difficult if not impossible to determine the empirical validity of the CNSFI. However, content validity was the relevant type of validity for this instrument and could be determined by several methods. Since content validity is a matter of judgment, there are no objective or quantifiable methods to use. The use of experts in the subject area and a specific plan for development are the best ways of

assuring content validity (Polit & Hungler, 1978). In this situation, when the intent is to measure the importance of functions of the clinical nurse specialist, it is imperative that the scale contain actual functions of the clinical nurse specialist.

The analysis of the 14 job descriptions of clinical nurse specialists which resulted in the categories of functions and attributes for the clinical nurse specialist (i.e., clinical, education, administration, research, and personal development and other) led to a rudimentary table of specifications or plan for the instrument development (i.e. the representative job description). It was decided to utilize statements which were descriptive of actual functions of the clinical nurse specialist and discard the attribute statements for this study. Therefore the four components of the clinical nurse specialist role were identified as clinical, education, administration, and research. This plan allowed the researcher to be certain that items in each category were included in the instrument. Secondly, since all items in the initial draft came from job descriptions of clinical nurse specialists, one could judge with some measure of confidence that these items reflected real expectations of performance for the clinical nurse specialist. In addition, the literature on clinical nurse specialists was reviewed.

Two further attempts to support the content validity

were made. First, structured interviews with clinical nurse specialists were conducted to insure that the statements reflected the functions of a clinical nurse specialist. Secondly, the inventory was sent to 25 clinical nurse specialists in the Kansas City area. They were requested to complete the inventory according to their perceptions of the importance of each function, to identify missing functions and to make any suggestions or criticisms about format and the like (see Appendix D). Responses were received from 24 of the 25 clinical nurse specialists contacted. Based on their comments, several revisions were made in the instructions and in the stating of a few items. One item (item 20 - "Contributes to the education of the public through participation in health oriented organization programs and/or membership activities") was added to the inventory because many of the clinical nurse specialists surveyed mentioned that function as a part of their responsibilities.

In summary, because of the nature of the CNSFI, content validity was the revelant kind of validity to consider. With the combination of a plan for construction, use of items from actual job descriptions, review of literature, interviews with clinical nurse specialists and the review of the working draft by 24 practicing clinical nurse specialists, the CNSFI can be said to have content validity.

Description of the Populations and Samples

Identification of the Populations

Two independent populations were surveyed. Educators and employers of clinical nurse specialists in 11 Midwestern states were chosen as the populations. These particular populations were relevant because they are the individuals responsible for the education of clinical nurse specialists and responsible for the hiring of them upon completion of the educational process. A grant funded organization developed for the purpose of collecting information about graduate nursing programs in 13 Midwestern states, The Midwest Directory of Resources for Graduate Education in Nursing (LaBelle, Pender, & Goodman, 1976), maintained a roster of graduate nursing faculty in the geographical area. The original intent was to use this roster to provide a sampling frame for selection of the educator sample in this study. The states covered by this directory are North and South Dakota, Nebraska, Kansas, Oklahoma, Missouri, Iowa, Minnesota, Wisconsin, Michigan, Illinois, Indiana, and Ohio. (North and South Dakota were not used in this dissertation because they do not have NLN accredited master's programs in nursing). Another reason for selection of populations in these 11 states is that they are a group of states in which the ideas about nursing education and nursing service should tend to be more

alike than in states which are more geographically diverse. In addition, the Midwest is the area in which the majority of the graduates of the University of Kansas Master of Nursing Program choose to practice.

Educator Sampling Procedure

After obtaining the graduate faculty roster from the Midwest Directory of Resources for Graduate Education in Nursing (LaBelle, et. al., 1976), it was discovered that the roster contained only doctorally prepared graduate faculty. Since many graduate faculty in nursing are not yet doctorally prepared, a sample drawn from that population would not be representative of all graduate nursing faculty. Therefore, in order to obtain a listing of all graduate nursing faculty in the 11 state area, letters were sent to the Deans of all 21 NLN accredited master's programs in nursing requesting these listings (see Appendix E). All deans responded. One declined to send a list and one sent only the names of faculty who had agreed to participate (30% of that faculty). The faculty of these two schools were eliminated from the study. The other 19 schools sent lists of their graduate faculty. From this roster of 456 nursing graduate faculty, 200 were chosen by use of a list of computer generated random numbers. The number 200 was chosen because this large number could assure adequate participation on and representation on each item. In addition, the resources were

available for this comprehensive sampling.

Employer Sampling Procedure

Separate methods were used to identify the population of employers in hospitals and community health agencies from which the employers were sampled. First, the hospital employer population was gathered from the 1979 American Hospital Association Guide to the Health Care Field (AHA, 1979). Since the position of clinical nurse specialist is relatively new in the health field, it was supposed that larger hospitals would be more likely to have them as staff members. Therefore, all hospitals with 200 or above bed capacity in the 11 Midwestern states were chosen as the source of the employer population. Six hundred twenty seven hospitals were found which met this criterion. Secondly, the Departments of Health in each state were contacted, requesting lists of community health agencies including mental health centers. All 11 state health departments responded. From these lists, community health agencies were identified from cities with 100,000 or above population and from cities with a university preparing clinical nurse specialists as sources for the community health employer population. Non-profit agencies, i.e., City/County Health Departments, Visiting Nurse Association and agencies with three or more distinct types of health services were included. Again, the size of city

and/or agency and the presence of clinical nurse specialist masters programs were thought to increase the likelihood of a clinical nurse specialist being employed. One hundred ninety six community health agencies were identified as sources for this population.

In order to maintain the same ratio between hospitals and community health agencies in the sample as in the population, 24 percent community health agencies and 76 percent hospitals were chosen in the initial employer sample of 200 using a computer generated list of random numbers. Because it was anticipated that a sizable portion of the employers contacted would not employ clinical nurse specialists, the number 200 was arbitrarily chosen as the initial number to contact in order to determine the final number of contacts necessary to obtain a minimum of 150 completed employer CNSFIs.

Data Collection

Educator Data Collection

The CNSFI and a letter requesting participation in the study was sent to the sample of 200 graduate nursing educators in late September (see Appendix G for educator letters). It was timed to be received after the initial flurry of the semester's beginning and before the busy time of mid-term exams and term papers. Three weeks later a second mailing was sent to the non-respondents (see Appendix G for second request letter).

Employer Data Collection

The first mailing of the CNSFI to 200 potential employers occurred during May 1980 (see Appendix F for employer letter). It became evident that the majority of employers contacted did not employ clinical nurse specialists. Therefore, each employer reporting no clinical nurse specialist employees was replaced from the same population (i.e., hospital or community health agency) using the same lists of random numbers. This procedure continued throughout June and July. By late July, 344 employers had been contacted and 74 percent had replied. In those 255 replies, 86 employers of clinical nurse specialists had completed the CNSFI. Therefore approximately 33 percent of those responding employed clinical nurse specialists. Since the minimum employer sample size desired was 150, 250 more employers were selected using the same lists of random numbers. The number 250 was chosen based on the assumption that the ratio of employers to non-employers of clinical nurse specialists among the respondents and the overall response rate would be similar to the first group chosen. The second part of the sample was contacted in September and a second mailing was sent to the non-respondents in the first part of the sample. A second mailing to the second part of the sample was sent in October (see Appendix F).

Analysis of Data

Biographical and Institutional Data

Data relating to biographical and institutional characteristics have been analyzed using descriptive statistics, specifically, frequencies, percentages, and means. These statistical concepts are of use in organizing data and describing characteristics of the data which are of interest (Minium, 1970; Anastasi, 1976). These statistics have been computed using the Frequencies program of the Statistical Program for the Social Sciences (SPSS).

Hypothesis One

Hypothesis one states:

> There are no significant differences between employers and educators in their responses of perceived importance of each of the 37 functions on the Clinical Nurse Specialist Functions Inventory.

There are certain assumptions which must be identified as a basis for the data analysis methodology of hypothesis one. Random sampling techniques result in each possible sample from these populations having an equal possibility of being selected. Therefore, there is a likelihood that the samples will be representatives of the populations. The central limits theorem indicates that the random sampling distribution of means is likely to resemble a normal distribution, regardless of the shape of the population being sampled (Minium, 1970).

Therefore, needing a way to test the significance of the differences in the means of the two independent groups on the Clinical Nurse Specialist Functions Inventory and assuming the normal distribution of the sample, and interval level measurement, the t-test was chosen as the statistical method. Kerlinger (1979) says that this assumption of normality can be violated without damaging the results of a t-test, when the sample is large.

Means for each item in the Clinical Nurse Specialist Functions Inventory were calculated for the employer group and the educator group. The t-test for independent means was performed for each item to determine if any differences were statistically significant. In other words, these t-tests determine if the two groups value each function of the clinical nurse specialist alike or significantly differently. The T-Test subprogram of SPSS was used for the computation.

Hypothesis Two

Hypothesis two states:

> There are no significant differences between the employers' and educators' of clinical nurse specialists perceptions of the four components of the clinical nurse specialist role, i.e., the clinical component (items 1-11), the education component (items 12-20), the administration component (items 21-29), and the research component (items 30-37) in the Clinical Nurse Specialist Functions Inventory.

The scores of the items of each component (i.e., clinical, education, administrative and research) were

added to yield a mean subscore value for each component. T-tests were performed on each component mean to determine if the educators and employers of clinical nurse specialists view the importance of these components significantly differently.

Relationship Between Biographical and Institutional Variables and Perceived Importance of Each Function

The question of the relationship between the biographical and institutional variables and the perception of importance of each function of the clinical nurse specialist was not set forth as a hypothesis. Because of the large number of options within each biographical and institutional variable, it was thought to be advisable to look for trends in the data rather than to test hypotheses. Therefore these data were tabulated using the SPSS program Crosstabs. Contingency tables for each item and certain biographical and institutional variables were developed. The researcher inspected these tables to attempt to identify trends.

Summary of Methodology

In order to answer the questions itemized in the problem statement: (1) do employers and educators of clinical nurse specialists perceive the relative importance of specific functions of the clinical nurse specialist alike or differently? (2) do these employers and educators perceive the importance of four components of

the role of the clinical nurse specialist alike or differently? and (3) is there any relationship between the biographical and institutional variables and the perceptions of relative importance of the specific functions of the clinical nurse specialist?, the Clinical Nurse Specialist Functions Inventory was developed. This instrument was developed from actual job descriptions of the clinical nurse specialist, interviews with clinical nurse specialists and a review of the clinical nurse specialist literature.

Two independent groups were surveyed. Two hundred educators of clinical nurse specialists from an 11 state area of the Midwest were chosen by random selection from a sampling frame of 456 graduate nursing faculty in the Midwest. Five hundred eighty seven employers in hospital and community health agencies were chosen from a sampling frame of 771 employers from hospitals with more than 200 beds and community health agencies from cities with 100,000 and above populations.

Descriptive statistics, specifically frequencies, percentages and means were used to analyze the biographical and institutional characteristics. The t-test for independent means was used to test the two null hypotheses. Visual inspection of contingency tables was used to identify trends in relationship between biographical and institutional variables and the perception of

importance of specific functions of the clinical nurse specialist.

Chapter IV

Findings of the Investigation

The purpose of this study is to determine if educators and employers of clinical nurse specialists differ in their perceptions of the importance of the functions of clinical nurse specialists. The findings will be presented in four parts. Part One will consist of an examination of the response rates for the study. Part Two presents the biographical and institutional characteristics of the respondents. Part Three will deal with the findings relating to the two hypotheses and the relationship between biographical and institutional variables and the perception of importance of the specific functions of the clinical nurse specialist. Part Four will introduce findings which were not identified as purposes of this study.

PART ONE

Response Rate Data

Response rates can be calculated by various methods. Dillman (1978) identifies two commonly used procedures for this calculation. The first method is to determine the percentage of people in the original sample from whom

completed questionnaires were received. The second method calculates the percentage of contacts with eligible respondents. This excludes unmade contacts and ineligible individuals. Although, according to Dillman, this latter method tends to underestimate the response rate for a mail questionnaire, it seems to be better than the first method which reflects the researcher's financial situation rather than the inherent capability of the method to elicit completed responses. Therefore, the latter method will be used.

A sample of 200 graduate nursing faculty in 11 Midwestern states were contacted. One hundred forty five (73%) responded by the requested date. A second request was mailed to the non-respondents and 23 (41%) responded to this second request. Therefore, a total of 168 graduate faculty responded. However, in order to use Dillman's second method of calculating response rate, the 16 who declined to complete the Clinical Nurse Specialist Functions Inventory (CNSFI) because they did not teach clinical nurse specialists were subtracted from the original sample. This resulted in a sample number of 184. One hundred fifty two completed CNSFIs were returned for a response rate of 83 percent.

The employer sample consisted of two groups - the hospital employers and the community health agency employers. The response rate data will be presented

separately for each group and then considered for the total employer group.

Attempts were made to contact the sample of 450 hospital employers. One questionnaire was returned as undeliverable. Therefore, the sample number was 449. By the requested deadline date 281 (63%) of the hospital nursing service administrators had replied. Second requests were mailed to the 118 non-respondents. Fifty seven percent of these initial non-respondents replied to the second request. Therefore, a total of 401 hospital nursing service administrators responded. This is a response rate of 89 percent.

Question 1 of the CNSFI for employers asked if the agency employed clinical nurse specialists. If the answer to this question was no, the respondent was requested to indicate the name and address of the institution and return the questionnaire. If clinical nurse specialists were employed, the administrator was asked to complete the remainder of the inventory. Of the 401 hospital employer respondents, 243 (61%) did not employ clinical nurse specialists. This resulted in 158 CNSFIs completed by hospital employers of clinical nurse specialists.

One hundred forty two questionnaires were sent to community health administrators. Four were returned as undeliverable leaving a sample of community health

administrators of 138. Eighty seven administrators (63%) responded by the established deadline. Second requests were mailed to 38 administrators and 24 (63%) responded to this follow-up mailing. A total of 123 community health administrators responded. This is an 89 percent response rate. Of the 123 respondents, 91 (74%) did not employ clinical nurse specialists. This resulted in 32 CNSFIs completed by community health employers of clinical nurse specialists.

For the total employer sample, 587 eligible and reachable employers were contacted. Five hundred and twenty four employers responded. This is an 89 percent response rate for the total employer group. Of the 524, only 36 percent employed clinical nurse specialists, resulting in 190 CNSFIs completed by employers of clinical nurse specialists.

Combining the educator and employer groups, 771 eligible individuals were contacted. Six hundred seventy six individuals responded resulting in an overall response rate of 88 percent. A total of 342 CNSFIs were completed by employers and educators of clinical nurse specialists. (See Table 1 for a summary of response rates.)

The overall response rate of 88 percent compares favorably with Dillman's (1978) ideas of adequate response rates. He states that, for surveys of the

Table 1

Summary of Replies and Response Rates
of Educators and Employers

Type of Respondent	Number Sent	Non-Contacts or Ineligible Responses	Sample Number	Number of Responses	Response Rate	Responding Employers & Educators of CNSs
Educator	200	16	184	152	83%	152
Employer						
Hospital	450	1	449	401	89%	158
Community Health	142	4	138	123	89%	32
Employer Total	592	5	587	524	89%	190
TOTAL	792	21	771	676	88%	342

general public, response rates of 60 to 75 percent are achieved using his Total Design Method. For more homogeneous samples a higher rate, in the area of 85 percent, can be expected with this method. Parts of the Total Design Method were incorporated in this study.

In order to determine if the respondents to the first mailing were similar to the respondents who answered only after the second mailing, comparisons were made between initial and second request employer and educator respondents. A randomly selected series of ten educator initial respondents and ten educator second request respondents were chosen. The means of these two groups were compared by t-test on each item. There were no significant differences on any item between the initial and second request respondents. The same procedure was followed for employer initial respondees and second request respondees. No significant differences were found between these two groups. Therefore, one can assume that these groups were from the same populations.

Part Two

Biographical and Institutional Characteristics of the Respondents

Educators of Clinical Nurse Specialists

One hundred fifty two educators of clinical nurse specialists returned completed CNSFIs. Table 2 depicts the responses of the educators when asked to identify the clinical area in which they teach.

Table 2

Clinical Area in Which Educator Teaches

Clinical Area	Number (%)
Medical-Surgical Nursing	26 (23.0)
Pediatric Nursing	11 (9.7)
Maternity Nursing	9 (8.0)
Psychiatric Nursing	22 (19.5)
Community Health Nursing	26 (23.0)
Other[a]	19 (16.8)
Total	113 (100.0)

[a]Other includes gerontological nursing, nurse midwifery and clinical area combinations.

Note: On tables relating to educator biographical and institutional variables when the total does not equal 152, the question was non applicable to some respondents and/or some respondents did not answer the question.

The responses of these educators were spread fairly evenly across the possible categories. The highest number taught in medical surgical nursing and community health nursing while the fewest taught in maternity nursing.

Table 3 reveals the number of educators who teach in each of the selected functional area majors.

Table 3

Functional Area in Which Educator Teaches

Functional Area	Number	(%)
Education	28	(29.8)
Administration	13	(13.8)
Research	33	(35.1)
Education & Research	5	(5.3)
Education & Administration	5	(5.3)
Administration & Research	3	(3.2)
Other[a]	7	(7.5)
Total	94	(100.0)

[a]Other includes consultation, theory development and liaison role.

The largest number of educators indicated research as their subject area of teaching, the next largest number indicated education. Administration and some combination of the three followed in frequency.

Table 4 portrays the number of educators holding each academic rank.

Table 4

Academic Rank of Educators

Academic Rank	Number	(%)
Professor	25	(16.4)
Associate Professor	70	(46.1)
Assistant Professor	48	(31.6)
Instructor	9	(5.9)
Total	152	(100.0)

Almost half of the educators held the rank of Associate Professor. Sixty-two percent were at the rank of Associate Professor or above. Assistant Professor was the next most frequent rank indicated.

The length of experience teaching graduate nursing students is depicted in Table 5.

Table 5

Length of Experience Teaching
Graduate Nursing Students

Length of Time	Number	(%)
Less than 1 year	6	(3.9)
1-5 years	66	(43.4)
6-10 years	44	(28.9)
Longer than 10 years	36	(23.7)
Total	152	(100.0)

Sixty six of the educators had been teaching graduate students in nursing for between one and five years. Forty four had been teaching from between six and ten years. Thirty six had been teaching graduate students longer than ten years while only six had less than one year experience.

The number of educator respondents holding each academic degree as their highest degree is revealed in Table 6.

Table 6

Highest Degree Earned by Educators

Academic Degree	Number	(%)
Master in Nursing	55	(36.4)
Non-Nursing Masters	6	(4.0)
Doctorate in Nursing	11	(7.3)
Non-Nursing Doctorate	79	(52.3)
Total	151	(100.0)

The highest degree earned by the graduate faculty respondents most frequently was the doctoral degree. Seventy nine held doctoral degrees in non-nursing areas, while eleven held the doctorate in nursing. Fifty five graduate faculty reported the masters in nursing as their highest degree while five indicated a non-nursing masters as their highest degree.

Table 7 shows the decades in which the educator earned his/her last degree.

Table 7

Decade During Which Educator's Highest Degree Was Earned

Decade	Number (%)
1951 - 1960	10 (6.6)
1961 - 1970	41 (27.2)
1971 - 1980	100 (66.2)
Total	151 (100.0)

The majority of the educators earned their highest degree during the time period 1971-1980. Over one-quarter of them earned their highest degree during the years 1961-1970, while the remainder were awarded their highest degree from 1951-1960.

Information was sought about certain institutional characteristics, i.e. characteristics of the school of

nursing employing each educator. These charateristics were the types of clinical nurse specialists prepared, the number of clinical nurse specialists graduated each year, and the total enrollment of the nursing graduate program.

The most frequently mentioned clinical specialist majors were medical-surgical, pediatrics, psychiatry, maternity and community health. Over one half of the respondents indicated that their schools offered all five of these majors. Other majors frequently mentioned were gerontology, midwifery and primary care.

The size of program was determined two ways: (1) the number of clinical nurse specialist graduated each year and (2) the total enrollment. Table 8 depicts those respondents indicating the approximate number of clinical nurse specialists graduated each year.

Table 8

Number of Educators Teaching in Schools Graduating Clinical Nurse Specialists in Each Size Grouping Each Year

Size of Clinical Nurse Specialist Graduation Group	Number	(%)
Fewer than 10	15	(10.2)
10-25	45	(30.6)
More than 25	87	(59.2)
Total	147	(100.0)

Note. These 147 educators represent only 19 nursing master's programs.

More than one half of the respondents indicated that their program graduated more than 25 clinical nurse specialists per year. Over one quarter indicated their schools graduated between 10 and 25 clinical nurse specialists per year while the remainder indicated graduation of less than 10 clinical nurse specialists per year.

Table 9 illustrates the number of educators teaching in programs which held certain enrollment group sizes.

Table 9

Number of Educators Teaching in Programs with Different Total Enrollment Sizes

Total Enrollment Size	Number (%)
Fewer than 100	24 (16.3)
100-250	97 (66.0)
More than 250	26 (17.7)
Total	147 (100.0)

Note. These 147 educators represent only 19 nursing master's programs.

Only 16.3 percent of the educators taught in programs with less than 100 students enrolled per year. The majority taught in schools whose graduate nursing programs enrolled between 100 and 250 students per year.

The geographical locations of the schools in which the educators taught are indicated and compared with the location of the educators in the population in Table 10.

Table 10

Number of Educators Responding Who Teach in Schools in Different Geographical Areas Compared with Number from Different Geographical Areas in Population

Geographical Area	Number Responding Educators (%)	Numbers in Population (%)
Kansas, Nebraska, Missouri, Oklahoma	32 (21.1)	88 (19.3)
Iowa, Illinois, Indiana, Ohio	68 (44.7)	191 (41.9)
Minnesota, Wisconsin Michigan	52 (34.2)	177 (38.8)

Almost one half of the educators taught in schools located in the states of Iowa, Illinois, Indiana and Ohio. Approximately one quarter taught in schools in Kansas, Nebraska, Missouri and Oklahoma while the remainder taught in schools located in Minnesota, Wisconsin and Michigan. The percentages of responding educators from each geographical area are similar to the percentage of educators from each area in the population.

Employers of Clinical Nurse Specialists

One hundred ninety employers of clinical nurse specialists returned completed CNSFIs. Table 11 presents the number of employers indicating specific positions of the employers.

Table 11

Number of Employers Indicating
Different Administration Positions

Position	Number	(%)
Director of Nursing[a]	152	(80.0)
Assistant or Associate Director of Nursing	12	(6.3)
Supervisor	2	(1.1)
Other[b]	24	(12.6)
Total	190	(100.0)

[a]This category also includes those whose official titles were Assistant or Associate Administrator, or Vice President but whose responsibilities included Nursing Service.

[b]Other includes non-nursing administrators in community health agencies.

The vast majority of these respondents were the chief nursing service administrator of the agency. Eighty percent or 152 individuals identified their position as Director of Nursing or equivalent. Twelve identified themselves as assistant or associate directors of nursing while two were supervisors.

The length of time the employer has held the present position is illustrated in Table 12.

Table 12

Length of Time Employer Has
Held Present Position

Length of Time	Number of Employers	(%)
Less than one year	38	(20.0)
1-5 years	80	(42.1)
6-10 years	43	(22.6)
Longer than 10 years	29	(15.3)
Total	190	(100.0)

Approximately 38 percent of the employers had held these positions for 6 years or longer. Forty-two percent had held these positions for between one and five years, while 20 percent had been in that position for less than one year.

Table 13 presents the number of employers holding each of the different degrees as their highest degree.

Over one half of the employers held a masters degree in nursing. Approximately 18 percent held a non-nursing masters while approximately 5 percent held a doctoral degree (2 degrees in nursing and 7 in non-nursing fields). Eighteen percent of the employers had a bachelor's degree or less.

Table 13

Highest Degree Earned by Employers

Degree	Number of Employers	(%)
Diploma in Nursing	7	(3.7)
Bachelor of Science in Nursing	15	(7.9)
Non-nursing Bachelors	12	(6.3)
Master in Nursing	113	(59.5)
Non-Nursing Masters	34	(17.9)
Doctorate in Nursing	2	(1.1)
Non-Nursing Doctorate	7	(3.7)
Total	190	(100.0)

Table 14 illustrates the number of employers who earned their highest degrees in selected decades. Most educators received their highest degree within the last ten years. Only 9 had received their highest degree before 1951. Approximately 40 percent received the degree between 10 and 30 years ago.

Table 14

Number of Employers Earning Highest Degree During Selected Decades

Decade	Number	(%)
Before 1951	9	(4.8)
1951 - 1960	20	(10.7)
1961 - 1970	54	(28.9)
1971 - 1980	104	(55.6)
Total	187	(100.0)

NOTE: On tables relating to employer biographical and institutional variables, when the total does not equal 190 the question was not applicable to some repondents and/or some respondents did not answer the question.

Table 15 depicts the number of respondent employers holding positions in different types of agencies employing clinical nurse specialists. The majority (54.2%) of the employers held positions in private community hospitals. Almost 30 percent were employed by public hospitals. Approximately 17 percent were employed in community health agencies (20 outpatient agencies and 12 community mental health outpatient centers). One special service agency, a federal prison hospital, was represented.

Table 15

Number of Employers Holding Positions in Different Types of Agencies

Type of Agency	Number	(%)
Private Community Hospitals	103	(54.6)
Public Hospitals	53	(28.1)
Community Out-Patient Agencies	20	(10.7)
Community Mental Health Agencies	12	(6.4)
Special Service Agencies	1	(.2)
Total	189	(100.0)

Over half (51%) of the hospitals had between 401 and 800 beds. The next largest group (33%) was in the 200 to 400 bed category. Sixteen percent of the hospitals were larger than 800 beds. An attempt was made to determine the size of the community health agencies by asking each employer to respond to pre-determined size categories. The categories did not include large enough case load sizes to discriminate among the community health agencies sizes because 88 percent of those responding indicated the largest case load size, i.e. over 1000.

Each employer was asked how many clinical nurse specialists were employed by his/her agency. Table 16 shows the number of agencies employing different numbers of clinical nurse specialists. Fifty six employers (30%)

Table 16

Number of Agencies Employing Different Numbers of Clinical Nurse Specialists

Number of Clinical Nurse Specialists Employed	Number of Agencies (%)
1	56 (30)
2 - 5	99 (52)
6 - 10	26 (14)
11 - 15	6 (3)
16 - 20	2 (1)
Total	189 (100)

reported employing the clinical nurse specialist in his/her agency. Fifty-two percent reported hiring from two to five clinical nurse specialists. Fourteen percent indicated hiring from 6 to 10 clinical nurse specialists. One employer reported employing 20 clinical nurse specialists. The mean number of clinical nurse specialists employed in each agency was 3.41.

In order to determine the length of experience of each agency with the clinical nurse specialist role, the respondents were asked to indicate the number of years that clinical nurse specialists had been employed in the agency. Table 17 displays these results. Forty percent indicated clinical nurse specialists had been employed

Table 17

Number of Years Clinical Nurse Specialists Have Been Employed in Agency

Number of Years	Number of Agencies	(%)
Less than 1	25	(13.2)
1 - 5	76	(40.2)
6 - 10	76	(40.2)
More than 10	12	(6.3)
Total	189	(100.0)

between one and five years ago and another 40 percent indicated first employment of the clinical nurse specialist between six and ten years ago. Therefore over 80 percent of the agencies had employed clinical nurse specialists for between one and ten years. Thirteen percent had first hired the clinical nurse specialist during this last year while six percent indicated over 10 years experience with this category of nursing position.

In an effort to identify the clinical areas of the clinical nurse specialist employed in each agency, the employer was asked to indicate the number of clinical nurse specialists employed in each major clinical area, i.e., Medical Surgical, Pediatric, Maternity, Psychiatry, Community Health Nursing and other. Twenty three agencies employed 45 clinical nurse specialists which

they identified as having a clinical specialty which could be categorized as "other". These clinical areas included gerontology, primary care and combinations of the usual clinical areas. Table 18 provides the information regarding the number of clinical nurse specialists in each clinical area employed by each agency.

Only 35.3 percent of the employers indicated that they hired no medical-surgical clinical nurse specialists. Thirty-one percent of the employers indicated their agency hired one medical surgical clinical nurse specialist. Twenty-eight percent of the employers employed from two to five medical surgical clinical nurse specialists while five percent employed from six to nine medical surgical clinical nurse specialists. The mean number of medical-surgical clinical nurse specialists employed in these agencies was 2.3.

One hundred forty six agencies (77%) represented did not hire pediatric clinical nurse specialists. The employment of one pediatric clinical nurse specialist was reported by 28 agencies (14%). The largest number of clinical nurse specialists employed in one agency was 12. The remaining 14 agencies (8%) employed from two to six pediatric clinical nurse specialists. The mean number of pediatric clinical nurse specialists employed in the 43 agencies was 2.0 clinical nurse specialists.

One hundred fifty agencies (79.4%) did not employ

Table 18

Number of Agencies Employing Different Numbers of Specific Types of Clinical Nurse Specialists

Type of Clinical Nurse Specialist	Number of Clinical Nurse Specialists in Each Agency					
	0	1	2-5	6-9	10-13	Mean
	Number of Agencies (%)					
Medical Surgical	67 (35.5)	59 (31.3)	53 (28.1)	10 (5.1)	0	2.3
Pediatric	146 (77.2)	28 (14.8)	13 (7.0)	1 (.5)	1 (.5)	2.0
Maternity	150 (79.4)	32 (16.9)	7 (3.7)	0	0	1.2
Psychiatric	77 (40.7)	78 (41.3)	33 (17.5)	1 (.5)	0	1.5
Community Health	169 (89.4)	16 (8.5)	4 (2.1)	0	0	1.1

maternity clinical nurse specialists. Thirty-two agencies (16.9%) each employed one maternity clinical nurse specialist, while five agencies each employed two and two agencies each employed three. The mean number of maternity clinical nurse specialists employed was 1.2.

One hundred twelve agencies (59.3%) employed psychiatric clinical nurse specialists while 77 (40.7%) did not have psychiatric clinical nurse specialist employees. Twenty-eight agencies (41.3%) each employed one psychiatric clinical nurse specialist. The largest number of psychiatric clinical nurse specialists employed by one agency was seven. The mean number of psychiatric clinical nurse specialists employed by these agencies was 1.5.

One hundred and sixty nine agencies (89.4%) did not employ community health clinical nurse specialists. Sixteen agencies (8.5%) each employed one community health clinical nurse specialist, while one agency reported employing three and one agency reported employing four. The mean number of community health clinical nurse specialists employed in these agencies was 1.1.

The employers reported that a total of 650 clinical nurse specialists were employed by the agencies reporting. Table 19 depicts the number of clinical nurse specialists in each clinical area employed by the 189 agencies represented in this study.

Table 19

Number of Clinical Nurse Specialists Employed in Each Clinical Area Specialty

Clinical Area	Number of Clinical Nurse Specialists	(%)
Medical Surgical	281	(43.2)
Pediatrics	86	(13.2)
Maternity	48	(7.4)
Psychiatric	168	(25.9)
Community Health	22	(3.4)
Other[a]	45	(6.9)
Total	650	(100.0)

[a]Other includes gerontology, primary care and combinations of the clinical areas.

The largest number of clinical nurse specialists were medical surgical clinical nurse specialists. Psychiatric clinical nurse specialists were the next largest group, followed in descending order by pediatric clinical nurse specialists, maternity clinical nurse specialists, other clinical nurse specialists and the smallest group, the community health clinical nurse specialist.

Table 20 depicts the location of the agencies in which the responding employers worked as compared with the location of agencies in the population. As with the

Table 20

Location of Agencies in Which Responding Employers Work as Compared with the Locations of All Agencies in the Population

Location	Number of Responding Employers	(%)	Number in Population of Agencies	(%)
Kansas, Nebraska Missouri, Oklahoma	39	(20.5)	165	(20.0)
Iowa, Illinois Indiana, Ohio	99	(52.1)	451	(54.8)
Minnesota, Wisconsin Michigan	52	(27.4)	207	(25.2)

educators, the majority of employers (52.1%) worked in institutions in the Iowa, Illinois, Indiana, Ohio area. Twenty seven percent worked in Minnesota, Wisconsin or Michigan while 20.5 percent worked in Kansas, Nebraska, Missouri and Oklahoma. The percentages of the employer respondents from each location compared very favorably with the percentage from each location in the employer population.

Discussion of Biographical and Institutional Characteristics of Educators and Employers of Clinical Nurse Specialists

The gathering of biographical institutional characteristics data assists in a better understanding of the respondents and their particular frames of reference.

An overwhelming majority (80%) of the employer group hold the highest position in nursing service administration while the majority (62.5) of the educators hold Associate Professor or above academic rank. Thus one could say that the majority of the respondents held a high rank within the chosen field.

The employers and educators appeared to have similar lengths of experience in their teaching or administrative capacity. Approximately 40 to 50 percent of both groups had 6 years or longer experience and 42-43 percent had been in similar positions for between 1-5 years. The employer and educator groups were, on the whole, experienced in their professions.

As one would expect, the educator group was the more highly educated with 59.6 percent holding doctorates as compared to 4.1 percent of the employers having earned the doctorate. One hundred percent of the educators held a masters degree or above while 82.2 percent of the employers held masters degrees or above. Therefore both groups could be viewed as highly educated. Fifty five percent of the employers earned the highest degree in the last ten years while 66.2 percent of the educators earned the highest degree in those 10 years. Between 83 and 85 percent of both groups earned the highest degree in the last 20 years indicating that both groups formal educational activities were fairly recent.

Both groups were employed in agencies or schools of substantial size. Sixty seven percent of hospital employers were from institutions with more than 400 beds, while 83.7 percent of the educators were from schools with a total graduate nursing enrollment of 100 students or more.

Although this study was not intended to count clinical nurse specialists in these 11 Midwest states, the information regarding numbers of clinical nurse specialists employed gives an interesting picture of the specialty areas most utilized, i.e. medical surgical (43.2%) and psychiatric (25.9%) and the large number (650) of clinical nurse specialists represented in the sample. Many of these 190 employers (70%) had experience with more than one clinical nurse specialist in their agencies which would lend credence to their ideas regarding the importance of functions of the clinical nurse specialist.

In general then, these two groups seemed to be highly qualified to be able to judge the relative importance of specific functions of the clinical nurse specialist. This competence is based upon their general high level of recent education, on experience and responsibility, and on their contact with substantial numbers of clinical nurse specialist students or practitioners.

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PART THREE

Testing of Hypothesis One

One hundred ninety employers of clinical nurse specialists and 152 educators of clinical nurse specialists completed the 37 item Clinical Nurse Specialist Function Inventory. Each respondent indicated on a five point scale the level of importance she/he placed upon that function for the clinical nurse specialists educated or employed by their institution. The scale was: 0 = not expected, 1 = slightly important; 2 = important, 3 = very important and 4 = utmost importance. Mean scores for the two independent groups were calculated for each item and t-tests were performed on these independent means using the SPSS computer program. The level of significance chosen was .01. This conservative level was chosen to decrease the possibility of Type 1 error due to repeated t-tests on the same subjects. Two-tailed probabilities calculated using the separate variance estimates were used.

In order to translate the mean scores of the employer and educator groups into categories which can be described by the value labels utilized in the scale, the following arbitrary breakdown was used.

Not in Position	Slightly Important	Important	Very Important	Utmost Importance
-.5001 - +.5000	.5001- 1.5000	1.5001- 2.5000	2.5001- 3.5000	3.5001- 4.5000

Because hypothesis two will study the four components of the role of the clinical nurse specialist which are derived by adding scores for the groups of related individual functions, the examination of the individual functions and testing of hypothesis one was organized into the four components for convenience and clarity. There should be no doubt however, that hypothesis one was concerned with each individual function while hypothesis two was concerned with the four components of the role of the clinical nurse specialist.

Hypothesis One

Hypothesis one stated: There are no significant differences between employers and educators in their responses of perceived importance of each function on the Clinical Nurse Specialist Functions Inventory.

Analysis of Functions 1 through 11 (Clinical Functions) Table 21 depicts the results of the t-tests on the 11 individual functions identified as primarily clinical.

In terms of the results reported in Table 21, one can say:

TABLE 21

Differences Between Employers and Educators Mean Valuation Scores on the Eleven Individual Functions Identified as Primarily Clinical

Function	Employer Mean	Educator Mean	T-Value
1. Assesses patient problems.	3.5753 n = 186	3.7770 n = 148	-2.74*
2. Establishes a nursing diagnosis.	3.2541 n = 185	3.5000 n = 148	-2.30
3. Establishes long and short term goals for care of individual patients.	3.2312 n = 186	3.6309 n = 149	-4.59*
4. Prescribes nursing interventions.	3.4247 n = 186	3.6892 n = 148	-3.27*
5. Administers routine direct patient care.	1.182 n = 188	1.211 n = 149	-4.95*
6. Administers specialized direct patient care.	2.9255 n = 188	3.2808 n = 146	-3.45*
7. Initiates health teaching to be done by other nursing personnel for patients and families based on nursing assessment.	3.0952 n = 189	3.1361 n = 147	-0.35
8. Implements health teaching for patients and families based on nursing assessment.	2.9048 n = 189	3.4306 n = 144	-5.00*
9. Assesses quality of nursing care in specific area.	3.0856 n = 187	3.5473 n = 148	-4.51*
10. Promotes upgrading of nursing care in specific area.	3.5026 n = 189	3.7181 n = 149	-2.76*
11. Coordinates patient care with other disciplines or departments.	2.8989 n = 188	3.3041 n = 148	-3.74*

*Significant at $p < .01$ level, 2 tailed test.

Function 1: Assesses patient problems.

The employer mean was 3.5753 while the educator mean was 3.7770. Both groups saw this function as of utmost importance. However, the t-test revealed a difference between the scores which was significant ($p = .006$). The educators saw this function as significantly more important than the employers.

Function 2: Establishes a nursing diagnosis.

The employer mean score was 3.2541 and the educator mean was 3.5000. Both groups saw this as a very important function. There was no significant difference between the educator and employer groups valuation on this function.

Function 3: Establishes long and short term goals for care of individual patients.

The mean score for the employer group was 3.2312. The mean score for the educator group was 3.6309. The employers saw this function as very important while the educators saw it as of utmost importance. The difference in the mean was significant ($p = .000$).

Function 4: Prescribes nursing interventions.

The employer mean was 3.4247. The educator mean was 3.6892. The employers valued this function as very important while the educators valued it as of utmost importance. The difference in the means was significant ($p = .001$).

Function 5: Administers routine direct patient care.

The employer mean was 1.3564. The educator mean was 2.0067. The employers viewed this function as only slightly important while the educators saw it as important. The difference between the two means was significant (p = .000).

Function 6: Administers specialized direct patient care.

The employer mean was 2.9255. The educator mean was 3.2808. Both groups valued this function as very important. However, there was a significant difference between the groups (p = .001) with the educator group giving a higher value.

Function 7: Initiates health teaching to be done by other nursing personnel for patients and families based on nursing assessment.

The employer mean was 3.0952. The educator mean was 3.1361. Both groups viewed this function as very important. There was no significant difference between the groups valuation of this function.

Function 8: Implements health teaching for patients and families based on nursing assessment.

The employer mean was 2.9048. The educator mean was 3.4306. While both groups viewed this function as very important, the educators viewed it as more important than the employers. This difference was significant (p = .000).

Function 9: Assesses quality of nursing care in specific area.

The employer mean was 3.0856. The educator mean was 3.5473. The employers valued this function as very important while the educators felt it was of utmost importance. The difference between these two means was significant ($p = .000$).

Function 10: Promotes upgrading of nursing care in specific area.

The employer mean was 3.5026. The educator mean was 3.7181. Both groups viewed this function as very important although the educators valued it significantly higher ($p = .006$).

Function 11: Coordinates patient care with other disciplines or departments.

The employer mean was 2.8989. The educator mean was 3.3041. Both groups viewed this function as very important but the educators valued it at a higher level than the employers. This difference in means was significant ($p = .000$).

Discussion of Results for Clinical Functions (1-11)

It is apparent that both the employers and educators value the individual clinical functions at high levels except for the function of administering routine direct patient care. This general high value is to be expected when one reviews the clinical nurse specialist literature which states that the primary goal of the clinical nurse

specialist is to provide expert nursing care to a special and specific kind of patient. The lower valuing of the administration of routine direct patient care may reflect the notion that routine care does not demand the expert skills and knowledge of the clinical nurse specialist. In the 9 of 11 instances where there are significant differences between the educators and employers, (Functions 1, 3, 4, 5, 6, 8, 9, 10 & 11) these differences are not in the direction of the valuation but in the level of valuation. In each instance the educators placed a higher value on the function than the employer.

Analysis of Functions 12-20 (Education Functions)

Table 22 depicts the results of the t-test on the nine individual functions identified a primarily educational.

In terms of the results in Table 22, one can say:

Function 12: Develops assessment and evaluation tools to assist staff in planning and providing patient care.

The employer mean was 3.1217. The educator mean was 3.2770. Both groups valued this function as very important. There was no significant difference between the groups.

Function 13: Acts as consultant for nursing staff.

The employer mean was 3.6789. The educator mean was 3.6679. Both groups viewed this function as of utmost importance. There was no significant difference between the groups.

TABLE 22

Differences Between Employers and Educators Mean Valuation Scores on Nine Individual Functions Identified as Primarily Educational

	Function	Employer Mean	Educator Mean	T-Value
12.	Develops assessment and evaluation tools to assist staff in planning and providing patient care.	3.1217 n = 189	3.2770 n = 148	-1.52
13.	Acts as consultant for nursing staff.	3.6789 n = 190	3.6779 n = 149	0.02
14.	Acts as consultant for medical staff.	2.6508 n = 189	3.2416 n = 149	-4.81*
15.	Provides assistance to nursing staff in meeting identified patient and family health education needs.	3.2474 n = 190	3.3649 n = 148	-1.26
16.	Participates in formal and informal inservice education for non-nursing health personnel.	2.1158 n = 190	2.1081 n = 148	0.06
17.	Participates in formal and informal inservice education for nursing personnel.	3.3704 n = 189	3.1622 n = 148	2.24
18.	Serves as a role model for nursing students.	2.6614 n = 189	3.4054 n = 148	-6.24*
19.	Assists with clinical and theoretical teaching of nursing students.	1.5789 n = 190	2.5705 n = 149	-7.35*
20.	Contributes to the education of the public through participation in health oriented organization programs and/or membership activities.	2.4842 n = 190	2.9189 n = 148	-3.83*

*Significant at $p < .01$ level, 2 tailed test.

Function 14: Acts as consultant for medical staff.

The employer mean was 2.6508. The educator mean was 3.2416. While both groups viewed this as very important, the educators valued it significantly higher than the educators. This difference was significant ($p = .000$).

Function 15: Provides assistance to nursing staff in meeting identified patient and family health education needs.

The employer mean was 3.2474. The educator mean was 3.3649. Both groups saw this function as very important. There was no signficant difference between the means of the two groups.

Function 16: Participates in formal and informal inservice education for non-nursing health personnel.

The employer mean was 2.1158. The educator mean was 2.1081. Both groups viewed this function as important. There was no signficant difference between the groups.

Function 17: Participates in formal and informal inservice education for nursing personnel.

The employer mean was 3.3704. The educator mean was 3.1622. Both groups valued this function as very important. There was no significant difference between the two groups.

Function 18: Serves as a role model for nursing students.

The employer mean was 2.6614. The educator mean was 3.4054. While both group means were in the very important value category, there was a significant

difference between these means. The educator group valued this function signficantly more highly than the employer group (p = .000).

Function 19: Assists with clinical and theoretical teaching of nursing students.

The employer mean was 1.5789. The educator mean was 2.5705. The employers viewed this function as important while the educators viewed it as very important. There was a significant difference between the means (p = .000).

Function 20: Contributes to the education of the public through participation in health oriented organization programs and/or membership actitivties.

The employer mean was 2.4842. The educator mean was 2.9189. The employers viewed this function as important while the educators viewed it as very important. There was a significant difference between these means with a p of .000.

Discussion of Results for Clinical Functions (12-20)

The employers and educators are in agreement on the valuation of five of the educational functions and have significant differences on the other four functions. The four functions on which they agree and tend to value as very important are functions involving educational efforts with nursing personnel. The one item on which they agree but evaluate as having a lower level of importance, i.e., "important", has to do with providing

educational service for non-nursing personnel.

On the four functions on which there are significant differences, the educators valued each function at a higher level than the employers. Acting as a consultant to medical staff (Function 14) was seen as less important by employers than educators. This difference may be the result of the wishes of the educators to move nursing into a more collegial relationship with medicine. The functions relating to education of student nurses (Function 18 and 19) and the function relating to education of the public (Function 20) were valued by educators more highly than employers. This result could be expected on the basis of the greater degree of involvement of educators in those areas.

Analysis of Functions 21-29 (Administrative Functions) Table 23 depicts the results of the t-tests on the nine individual functions identified as primarily administrative.

In terms of the results in Table 23 one can say:

Function 21: Participates in institutional committees which influence or determine policies affecting nursing practice.

The employer mean was 3.000. The educator mean was 3.5135. The employers saw this function as very important while the educators saw it as of utmost importance. The differences between the means was significant with a p value of .000.

TABLE 23

Differences Between Employers and Educators Mean Valuation Scores on Nine Individual Functions Identified as Primarily Administrative

	Function	Employer Mean	Educator Mean	T-Value
21.	Participates in institutional committees which influence or determine policies affecting nursing practice.	3.000 n = 190	3.5135 n = 148	-5.20*
22.	Takes leadership in defining, maintaining and interpreting standards of nursing practice.	3.1947 n = 190	3.7027 n = 148	-5.75*
23.	Participates in formal evaluation of nursing practice.	1.3684 n = 190	1.9592 n = 147	-4.45*
24.	Has responsibility for all nursing activities in a clinical area.	0.7394 n = 188	1.2432 n = 148	-3.71*
25.	Participates in decisions regarding employment of nursing personnel.	0.7861 n = 187	1.6259 n = 147	-6.62*
26.	Participates in decisions regarding termination of nursing personnel.	0.8457 n = 188	1.5374 n = 147	5.45*
27.	Takes leadership in the development and maintenance of a system of peer review for nursing personnel.	1.6296 n = 189	2.3878 n = 147	-5.14*
28.	Participates in evaluating conditions, resources, and policies essential to the delivery of nursing care service.	2.4895 n = 190	3.1284 n = 148	-5.44*
29.	Monitors changing needs of clinical area and institutes appropriate change.	2.3000 n = 190	3.0884 n = 147	-6.15*

*Significant at $p < .01$ level, 2 tailed test.

Function 22: Takes leadership in defining, maintaining and interpreting standards of nursing practice.

The employer mean was 3.1947. The educator mean was 3.7027. The employers valued this function as very important while the educators valued it as of utmost importance. The difference between these valuations was significant with a p value of .000.

Function 23: Participates in formal evaluation of nursing personnel.

The employer mean was 1.3684. The educator mean was 1.9592. The employers viewed this function as slightly important while the educators viewed it as important. The difference between these means was significant with a p value of .000.

Function 24: Has responsibility for all nursing activities in a clinical area.

The employer mean was 0.7394. The educator mean was 1.2432. Both groups valued this function as slightly important but the educators valued it significantly higher than the employers (p = .000).

Function 25: Participates in decisions regarding employment of nursing personnel.

The employer mean was 0.7861. The educator mean was 1.6259. The employers viewed this function as slightly important while the educators viewed it as important. The educators saw it as significantly more important than the administrators (p = .000).

Function 26: Participates in decisions regarding termination of nursing personnel.

The employer mean was 0.8457. The educator mean was 1.5374. The employers valued this function as slightly important while the educators valued this function as important. The difference in the means was significant with a p value of .000.

Function 27: Takes leadership in the development and maintenance of a system of peer review for nursing personnel.

The employer mean was 1.6296. The educator mean was 2.3878. Both groups saw this function as being important. However, the educators valued it significantly more highly than the employers ($p = .000$).

Function 28: Participates in evaluating conditions, resources, and policies essential to the delivery of nursing care service.

The employer mean was 2.4895. The educator mean was 3.1284. The employers viewed this function as important while the educators valued it as very important. The difference in the means was significant with the p value of .000.

Function 29: Monitors changing needs of clinical area and institutes appropriate change.

The employer mean was 2.3000. The educator mean was 3.0884. The employers viewed this function as important while the educators viewed it as very important. The difference in the means was significant with a p value of .000.

Discussion of Results for Administrative Functions (21-29) The results for the administrative functions are interesting because they do not seem to be in agreement with the clinical nurse specialist literature or with the commonly held interests of each respondent group. There are significant differences between the educator and employer means. The educators place a higher value on every administrative function than the employers. The overall value level from both groups for the administrative functions are not as high as for the clinical and educational functions. Since the administrative role is seldom mentioned in the clinical nurse specialist literature (and almost never mentioned by clinical nurse specialist literature written by educators) it seems unusual that the educators should value it higher than the employers. In addition, one would think that administrators would value their own particular area of interest and expertise more highly and at least give more importance to some of those functions than educators.

One explanation for this discrepancy could be that the employers have staff members specifically employed to carry out these administrative duties. Although job descriptions of the clinical nurse specialist do include administrative duties, the employers expect them to focus more on the other components of the role.

Analysis of Functions 30-37 (Research Functions)

Table 24 depicts the results of the t-test on the eight individual functions identified as primarily research. In terms of the results in Table 24, one can say:

Function 30: Assesses the needs for nursing research in clinical area.

The employer mean is 2.7090. The educator mean is 3.3224. While both groups valued this function as very important, the educators valued it significantly higher than the employers ($p = .000$).

Function 31: Identifies relevant clinical questions appropriate for systematic study.

The employer mean was 2.7513. The educator mean was 3.5033. The educators valued this function as of utmost importance while the employers viewed it as very important. The difference in the mean scores was significant. ($p = .000$).

Function 32: Plans nursing studies according to accepted nursing research standards.

The employer mean was 2.5185. The educator mean was 3.0861. Both groups saw this function as very important. However, the difference between the means was significant with the educator group assigning the highest value ($p = .000$).

Function 33: Conducts research relating to nursing practice.

The employer mean was 2.4974. The educator mean was

TABLE 24

Differences Between Employers and Educators Mean Valuation Scores on Eight Individual Functions Identified as Primarily Research

	Function	Employer Mean	Educator Mean	T-Value
30.	Assesses the needs for nursing research in clinical area.	2.7090 n = 189	3.3224 n = 152	-5.55*
31.	Identifies relevant clinical questions appropriate for systematic study.	2.7513 n = 189	3.5033 n = 151	-7.58*
32.	Plans nursing studies according to accepted nursing research standards.	2.5185 n = 189	3.0861 n = 151	-4.51*
33.	Conducts research relating to nursing practice.	2.4974 n = 189	2.9735 n = 151	-3.78*
34.	Evaluates the nursing research process.	2.4000 n = 190	2.8255 n = 149	-3.13*
35.	Interprets to nursing personnel the results of nursing research.	2.6684 n = 190	3.3311 n = 151	-5.80*
36.	Assists nursing personnel in utilizing research to effect change.	2.7579 n = 190	3.4200 n = 150	-5.88*
37.	Communicates results of research through presentations and publications.	2.5579 n = 190	3.1722 n = 151	5.15*

*Significant at $p < .01$ level, 2 tailed test.

2.9735. The employers saw this function as important while the educators saw it as very important. The difference in valuation was significant (p = .000).

Function 34: Evaluates the nursing research process.

The employer mean was 2.4000. The educator mean was 2.8255. The employers perceived this function as important while the educators viewed it as very important. The difference between the means was significant (p = .002).

Function 35: Interprets to nursing personnel the results of nursing research.

The employer mean was 2.6684. The educator mean was 3.3311. Both groups perceived this function as very important; however, the educators valued it significantly higher than the employers (p = .000).

Function 36: Assists nursing personnel in utilizing research to effect change.

The employer mean was 2.7579. The educator mean was 3.4200. Both groups viewed this function as very important. The level of importance indicated by the educators was significantly higher than the level indicated by the employers (p = .000).

Function 37: Communicates results of research through presentations and publications.

The employer mean was 2.5579. The educator mean was 3.1722. Both the employers and educators viewed this function as very important. However, the educators

valued it signficantly higher than the employers ($p = .000$).

Discussion of Results for Research Functions (30-37)

The educators value all research functions significantly higher than do employers. The levels of importance given by both educators and employers was somewhat below the levels given to clinical and educational functions. These results are in agreement with the clinical nurse specialist literature which almost always lists research as an integral part of the clinical nurse specialist role but not as a primary component. The higher regard demonstrated by the educators for research could be expected based upon the graduate nursing educators involvement and interest in the area.

Summary of Results of Hypothesis One

Hypothesis one stated:

There are no significant differences between employers and educators in their responses of perceived importance of each function on the Clinical Nurse Specialist Functions Inventory.

For 30 of the 37 functions in the CNSFI the hypothesis was rejected. There were significant differences between the employer and educator mean valuations on each of the 30 items. Therefore it can be said that the employers perceived a different level of importance for those 30 functions than the educators. Specifically, in

the clinical functions category Hypothesis one was rejected for functions which described assessment of patient problems (item 1), establishment of long and short term goals (item 3), prescription of nursing intervention (item 4), administration of routine direct care (item 5), administration of specialized care (item 6), implementation of health teaching (item 8), assessment of quality of nursing care (item 9), promotion of improvement in nursing care (item 10), and coordination of patient care (item 11). The clinical functions for which hypothesis one was accepted dealt with the establishment of a nursing diagnosis (item 2) and initiation of health teaching done by other nursing personnel (item 7).

The educational functions category yielded the largest number of items for which hypothesis one was accepted. The employers and educators tended to value these functions more alike than in any other category. Specifically, the hypothesis was accepted for functions which dealt with development of assessment and evaluation tools (item 12), consultation for nursing staff (item 13), assistance to nursing staff in meeting health education needs (item 15), participation in inservice education for non-nursing personnel (item 16), and participation in inservice education for nursing personnel (item 17). The hypothesis was rejected for functions which described consultation for medical staff

(item 14), role modeling for nursing students (item 18), assistance with teaching nursing students (item 19), and contributions to the education of the public (item 20).

Hypothesis one was rejected for all items in the administrative function category. These items dealt with participation in institutional committees (item 21), assumption of leadership in maintenance of standards of nursing practice (item 22), participation in formal evaluation of nursing personnel (item 23), assumption of responsibility for all nursing activities in a specific area (item 24), participation in employment decisions regarding nursing personnel (item 25), participation in termination decisions regarding nursing personnel (item 26), assumption of leadership in peer review activities (item 27), participation in evaluation of conditions, resources and policies essential to nursing service (item 28), and institution of appropriate changes (item 29).

Hypothesis one was also rejected for all functions in the research category. These functions concerned the assessment of needs for nursing research (item 30), identification of clinical questions for research (item 31), planning of nursing studies (item 32), conducting nursing research (item 33), evaluating that nursing research process (item 34), interpretation of results of nursing research (item 35), assisting nurses to utilize results of nursing research (item 36), and communication

of results of research (item 37).

Testing of Hypothesis Two

Hypothesis two stated:

There are no significant differences between employers' and educators' of clinical nurse specialists perceptions of the importance of the four components of the clinical nurse specialist role, ie., the clinical component (items 1-11), the education component (items 12-20), the administrative component (items 21-29), and the research component (items 30-37) in the Clinical Nurse Specialist Functions Inventory.

Analysis of the Results for the Four Components of the Role

The first 11 items (1-11) on the CNSFI were identified as primarily clinical functions. The responses on these items were added resulting in one mean score for employers and one mean score for educators. This resulted in the clinical component scores. The second nine items (12-20) were identified as primarily educational functions. The responses were also added resulting in a mean score each for employers and educators for the educational component. The same procedure was followed to obtain the administrative component scores (items 21-29), and the research component scores (items 30-37). T-tests were performed on the mean scores of the employers and educators on these four components using

the SPSS t-test program.

Table 25 depicts the results of the t-tests on each component, i.e., clinical, education, administration and research. In terms of the results reported in Table 25, one can say that there were significant differences between the employer and educator means for each component. For the clinical component, the employer mean was 3.055.

Table 25

Differences Between Employer and Educator Mean Valuation Scores on Each Component of the Clinical Nurse Specialist Role

Role Factor	Employer Mean	Educator Mean	T-Value
Clinical	3.055 n = 179	3.377 n = 140	-5.69*
Education	2.753 n = 186	3.081 n = 146	-4.87*
Administration	1.812 n = 184	2.477 n = 145	-7.78*
Research	2.610 n = 189	3.215 n = 148	-5.96*

*Significant at $p < .01$ level, 2 tailed test

The educator mean was 3.377. Using the previously established parameters for the descriptors, these means indicated that both groups viewed the clinical component as very important. However, the educators saw it as significantly more important than the employers ($p = .000$).

For the educational component, the employer mean was 2.753 and the educator mean was 3.081. Both groups viewed this component as very important. The educators perceived it as significantly more important; however ($p = .000$). For the administrative component, the employer mean was 1.812. The educator mean was 2.477. Both the educators and employers viewed this component as important, however, the educator mean was significantly higher than the employer mean ($p = .000$). For the research component, the employer mean was 2.610 and the educator mean was 3.215. Both groups viewed this component as very important but the educators valued it significantly more so than the employers ($p = .000$). Therefore, hypothesis two was rejected.

Discussion of the Analysis of the Four Components of the Clinical Nurse Specialist Role

Although the educators and employers of clinical nurse specialists viewed each component in the same general way (i.e., giving the same descriptive value), the actual mean values for each group were significantly different for each component. In each case the educators gave the component a higher value. This finding is in agreement with the findings in hypothesis one in which the educators gave the higher value to all functions except two educational functions (items 13 and 17). One explanation for this phenomenon may be that the educators

tend to award a greater importance to each function, viewing these functions and roles from a theoretical point of view. In other words, all these functions and components are relatively more important for the clinical nurse specialist to know, hence the higher value in the educator's eyes. The employers, on the other hand, have more direct experience with the necessity of setting priorities in the clinical setting. They may realize that while it may be important for the clinical nurse specialist to have information regarding all these areas, in the work setting decisions need to be made about which functions need to be carried out first in the event of time constraints. In that frame of reference, not everything can be viewed as of utmost importance or very important.

An interesting sidelight of the analysis of the four components is the ranking (by mean) given to the components by each group. The employers rank each component in descending order of importance (1) clinical, (2) education, (3) research and (4) administration. The educators rank each component (1) clinical, (2) research, (3) education and (4) administration. The educators view research as the second most important component while the employers view the educational component as second most important. This ranking by each group may be explained when one looks at the educational preparation of the

educator sample (majority of whom hold doctoral degrees). One would expect faculty with doctoral degrees in university settings to place a high value on research. In addition, educators look to research as the source of answers to many clinical problems. On the other hand, a primary concern of nursing service employers is the continual educational upgrading of their staff. One evidence of this is the presence of a staff development department in nearly every nursing service department in medium and large hospitals.

Summary of Findings for Hypothesis Two

When the scores for the functions regarded as primarily clinical, education, administration and research were each added together into their respective components, employer and educator means and T values for each component of the role were calculated. There were significant differences (level of significance p = .01) between the employer and educator groups on each component. The employer rankings (in descending order of importance) were: (1) clinical, (2) education, (3) research and (4) administration. The educator rankings were: (1) clinical, (2) research, (3) education and (4) administration.

Relationship Between Biographical and Institutional Variables and the Importance of Each Function

Analysis of Data

These data were tabulated using the SPSS program

Crosstabs. This SPSS program developed contingency tables for each selected biographical and institutional variable and each item. Because of the very frequent occurrence of cells with expected cell frequencies below five, the Chi Square statistical procedure for identifying relationships could not be used. Therefore, the selected employer and educator variables were examined informally for any discernable trends.

The educator biographical and institutional variables examined were (1) the clinical area in which the educator taught, (2) the functional area major in which the educator taught, (3) the academic rank of the educator, (4) the educator's length of experience teaching graduate nursing students, (5) the educator's highest degree earned, (6) the number of clinical nurse specialists graduated by the educator's school each year and (7) the geographical location of the educator's employing school of nursing. Upon examination of each contingency table for each biographical and institutional variable for each of the 37 items on the CNSFI, it was apparent that the variation in response on each item was not related to any of these variables.

The employer biographical and institutional variables examined were (1) the length of time the employer had held his/her present position, (2) the highest degree earned by the employer, (3) how recently this highest

degree was earned, (4) the type of agency employing the respondent, (5) the size of the employing hospitals and (6) the geographical location of the employing agency. Upon examination of each contingency table for the selected biographical and institutional variables and each of the 37 items on the CNSFI, it was determined that the variation in responses on these items was not related to any of the variables.

Discussion of the results

Although the researcher thought it probable that some biographical and institutional variables were related to the perceived importance of the functions of the clinical nurse specialist, the available data did not support this idea. Two explanations are possible. First, if a larger sample were surveyed in which an increased number of employers or educators were represented in each biographical and institutional variable, perhaps some significant relationships could be found. Secondly, it is possible that variables not measured in this study were responsible for the variation in responses on the 37 items of the CNSFI.

PART FOUR

Related Findings

Although it was not a specific purpose of this study, it was possible to develop a rank order (by mean

scores) listing of the most highly valued functions and the least highly valued functions of the clinical nurse specialist for the educator group and the employer group.

Table 26 depicts the 10 most important functions of the clinical nurse specialist as identified by the educators and employees. They are listed in descending order of importance.

The lists of the ten most highly valued functions of the clinical nurse specialists by educators and employers contained seven common items (items 1, 2, 3, 4, 10, 13 and 22). Five of these common items are clinical functions (items 1, 2, 3, 4, and 10), one is an education item (item 13) and one is an administration item (item 22). The educators' list contains six clinical functions (items 1, 2, 3, 4, 9 and 10), one education function (item 13), two administrative functions (items 21 and 22) and one research item (item 31). The employers' list contains five clinical functions (items 1, 2, 3, 4 and 10), four educational functions (items 12, 13, 15 and 17) and one administrator function (item 22).

Table 27 displays the ten least important functions of the clinical nurse specialist as identified by educators and employers. These functions are listed with the least important first.

The lists of the ten least valued functions of the clinical nurse specialist by educators and employers

TABLE 26

Ten Most Important Functions of the Clinical Nurse Specialist as Identified by Educators and Employers

Educators			Employers		
Rank	Item Number	Function	Rank	Item Number	Function
1	1	Assesses patient problems.	1	13	Acts as consultant for nursing staff.
2	10	Promotes upgrading of nursing care in specific area.	2	1	Assesses patient problems.
3	22	Takes leadership in defining, maintaining and interpreting standards of nursing practice.	3	10	Promotes upgrading of nursing care in specific area.
4	4	Prescribes nursing interventions.	4	4	Prescribes nursing interventions.
5	13	Acts as consultant for nursing staff.	5	17	Participates in formal and informal inservice education for nursing personnel.
6	3	Establishes long and short term goals for care of individual patients.	6	2	Establishes a nursing diagnosis.
7	9	Assesses quality of nursing care in specific area.	7	15	Provides assistance to nursing staff in meeting identified patient and family health education needs.

TABLE 26 - Continued

Educators			Employers		
Rank	Item Number	Function	Rank	Item Number	Function
8	21	Participates in institutional committees which influence or determine policies affecting nursing practice.	8	3	Establishes long and short term goals for care of individual patients.
9	31	Identifies relevant clinical questions appropriate for systematic study.	9	22	Takes leadership in defining, maintaining and interpreting standards of nursing practice.
10	2	Establishes a nursing diagnosis.	10	12	Develops assessment and evaluation tools to assist staff in planning and providing patient care.

TABLE 27

Ten Least Important Functions of the Clinical Nurse Specialist as Identified by Educators and Employers

Educators			Employers		
Rank	Item Number	Function	Rank	Item Number	Function
1	24	Has responsibility for all nursing activities in a clinical area.	1	24	Has responsibility for all nursing activities in a clinical area.
2	26	Participates in decisions regarding termination of nursing personnel.	2	25	Participates in decisions regarding employment of nursing personnel.
3	25	Participates in decisions regarding employment of nursing personnel.	3	26	Participates in decisions regarding termination of nursing personnel.
4	23	Participates in formal evaluation of nursing personnel.	4	5	Administers routine direct patient care.
5	5	Administers routine direct patient care.	5	23	Participates in formal evaluation of nursing personnel.
6	16	Participates in formal and informal inservice education for non-nursing health patients.	6	19	Assists with clinical and theoretical teaching of nursing students.
7	27	Takes leadership in the development and maintenance of a system of peer review for nursing personnel.	7	17	Participates in formal and informal inservice education for nursing personnel.

TABLE 27 - Continued

Educators			Employers		
Rank	Item Number	Function	Rank	Item Number	Function
8	19	Assists with clinical and theoretical teaching of nursing students.	8	16	Participates in formal and informal inservice education of non-nursing health patients.
9	34	Evaluates the nursing research process.	9	29	Monitors changing needs of clinical area and institutes appropriate change.
10	20	Contributes to the education of the public through participation in health oriented organization programs and/or membership activities.	10	34	Evaluates the nursing research process.

contained nine common functions (items 5, 16, 19, 23, 24, 25, 26, 27 and 34). Five of these common functions are administrative functions (items 23, 24, 25, 26 and 27), two are education functions (items 16 and 19), one is clinical (item 5) and one is research (item 34). The educators list contains five administration functions (items 23, 24, 25, 26 and 27), one clinical function (item 5), three education functions (items 16, 19 and 20) and one research function (item 34). The employers' list contains six administrative functions (items 23, 24, 25, 26, 27 and 29), one clinical function (item 5), two education functions (items 16 and 19) and one research function (item 34).

Both educators and employers choose clinical functions most often as their most highly valued functions. In addition, the ten items chosen by educators and employers tended to be the same items for both groups (70 percent agreement). Both groups valued those items in a similar direction even though the actual mean scores showed significant differences (by t-test) between the groups on five of the seven common items.

There was considerable agreement between the employer and educator groups on the ten functions least highly valued. Nine of the ten items were common to both groups. The majority of these functions were administrative.

Chapter V

Summary, Conclusions and Recommendations

Summary

This study was designed to determine if employers and educators of clinical nurse specialists held similar or different perceptions of the importance of functions of the clinical nurse specialists. Since the position of clinical nurse specialist is a relatively new one, most literature has focused upon the development of the role. This literature is written by persons functioning in the role or by educators, and tends to be oriented toward anecdotal experiences of the authors or opinions of the authors and not necessarily based upon a systematic study. Few researchers studied the actual responsibilities of the clinical nurse specialist and only one study (Bruce, 1971) could be located which attempted to identify the importance of specific functions of the clinical nurse specialist. The knowledge of similarities and differences in employers' and educators' perceptions of importance of functions of the clinical nurse specialist seemed to be a critical aspect of ongoing evaluation of a master program in nursing which prepares clinical nurse specialists. This information should be an important

tool for review and revision of objectives for clinical masters programs.

In order to assess the opinions of employers and educators of the clinical nurse specialist, an instrument was developed. The Clinical Nurse Specialist Functions Inventory (CNSFI) consisted of 37 items, each representing one function of the clinical nurse specialist. These functions were drawn from job descriptions of clinical nurse specialists, the literature regarding the clinical nurse specialists and structured interviews with practicing clinical nurse specialists. Each item fit into one of four components of the clinical nurse specialist role. These components were identified as clinical, education, administration, and research. Because biographical and institutional information was of interest, sets of questions relating to these areas were developed for the educators and employers.

Two independent groups were surveyed. One hundred eighty four educators of clinical nurse specialists were randomly selected from a sampling frame of 456 graduate nursing faculty in NLN accredited masters' programs in nursing from 11 Midwestern states. Five hundred eighty seven potential employers of clinical nurse specialists from hospitals and community health agencies were contacted. These 587 potential employers were randomly drawn from a sampling frame of 823 hospitals and

community health agencies in 11 Midwestern states. One hundred fifty two educators completed the CNSFI which was a response rate of 83%. Five hundred twenty four potential employers responded (89 percent response rate). Three hundred thirty four indicated no clinical nurse specialist employees; 190 returned completed CNSFIs thereby indicating clinical nurse specialist employees. The response rate combined for educators and employees was 88 percent.

Two hypotheses were stated in the null. Hypothesis one stated: There are no significant differences between employers and educators in their responses of perceived importance of each function on the Clinical Nurse Specialist Functions Inventory. Hypothesis one was rejected for 30 of the 37 items.

Hypothesis two stated: There are no significant differences between the employers' and educators' of clinical nurse specialists perceptions of the importance of the four components of the clinical nurse specialist role, i.e., the clinical component (items 1-11), the educational component (items 12-20), the administrative component (items 21-29) and the research component (items 30-37) the Clinical Nurse Specialist Functions Inventory. Hypothesis two was rejected for each of the four components of the role of the clinical nurse specialist.

There was no observable relationship between

selected biographical and institutional variables and the perceived importance of any individual function. Using the mean score for each item it was possible to identify the ten most highly valued functions for each group and the ten least valued functions for each group. The employer and educator rank order lists included many common items (seven of ten for the most highly valued functions and nine of ten for the least valued functions). The clinical functions were most frequently represented in the most highly valued list and administrative functions were most frequently represented on the least highly valued list.

Conclusions

1. The educators and employers of clinical nurse specialists hold significantly different values for the majority of the individual functions (30 of 37) included in the Clinical Nurse Specialist Functions Inventory.

2. The educators and employers of clinical nurse specialists hold signficantly different values for each of the four components of the clinical nurse specialist role. Both groups valued the clinical component highest and the administration component lowest. The employers ranked the education component in second place while the educators ranked research in second place.

3. The educators' mean valuations for each individual function and each component of the role of the

clinical nurse specialist were higher than the employers' mean valuations for an overwhelming majority of functions (35 of 37) and for all components of the role. The educators see an overall higher importance to these functions while the employers selected lower levels of importance. For example, the educators rated nine individual functions as of utmost importance while the employers rated only three as of utmost importance.

4. There were no biographical and institutional variables which could be identified as affecting the responses on any items of the CNSFI.

5. Although there were signficant differences between the independent means found on almost all individual functions and on all components of the role of the clinical nurse specialist, the two groups tended to view the functions in the same general direction of importance. The lists of most important items and least important items as identified by each group were similar (seven of ten common items on most important list and nine of ten common items on least important list).

6. Based upon the high response rate, there seems to be considerable interest in the role of the clinical nurse specialist. The number of clinical nurse specialists employed in the area is sizeable and many employers who did not currently have clinical nurse specialist employees indicated that they were in the process of

recruiting for those positions.

Comments on the Results

Several issues arising from the results and conclusions deserve further comment. Although the demographic information was not used extensively in the analysis, it does represent a collection of data for the Midwest which was not available elsewhere. It was extremely useful in documenting the credentials of the respondents in regard to their appropriateness as sources of opinions about clinical nurse specialists. Moreover, it gives information about several areas of general interest to nursing. Specifically, the level of education of the educators and employers was quite high. While this might be expected for the educators, the nursing administrators' educational level was higher than anticipated. Although it is commonly believed that the incidence of graduate education for nurses is increasing, these data support that belief. In addition, the recency of completion of the majority of the graduate degrees shows that this movement toward graduate education has gained momentum in the last decade.

The information obtained about clinical nurse specialists as reported by the employers is of wide interest to nursing educators and employers as well. That 52% of the agencies which hired clinical nurse specialists currently employ from two to five clinical

nurse specialists; 62% employ from two to ten clinical nurse specialists and two agencies each employ from 16-20 clinical nurse specialists is knowledge which supports the idea that the employers find the services provided by the clinical nurse specialists to be useful enough to hire more than one in each agency. This gives support to educators' efforts and could encourage potential employers to experiment with this new type of nursing employee. Since the majority of potential employers responding did not employ clinical nurse specialists (64%), there are still many sizeable hospitals and community health agencies in the Midwest which could serve as a source of employment for future clinical nurse specialists. Secondly, the clinical areas most often represented by employed clinical nurse specialists gives information about the utilization of these types of health professionals. The largest percentage of clinical nurse specialists were in the medical surgical clinical area (43.2%) followed by the psychiatric clinical area (25.9%), the pediatric clinical area (13.2%), the maternity clinical area (7.4%), and the community health clinical area (3.4%). While this information does not specifically address the perceived need for clinical nurse specialists in these clinical areas, it gives an idea about how employers have viewed the needs when hiring the present clinical nurse specialists for each

agency. Such information can be used for planning educational programs and counseling of students. The total number of clinical nurse specialists (650) employed by the responding administrators was larger than expected by the investigator. No statistics about numbers of clinical nurse specialists employed in the Midwest could be found in the literature, therefore no comparisons could be made.

This biographical and institutional information is the first compilation of such data for the Midwest and has many aspects which are of interest to nurses today. In addition, it can serve as a baseline for any future data which may be collected about employers and educators of clinical nurse specialists and the clinical nurse specialists themselves. As such, these data deserve reporting in this document.

The findings related to the significantly differing values held by the educators and employers regarding the importance of each of the functions of the clinical nurse specialist and the four components of the role were not unexpected. One of the reasons for implementing this study was the unsubstantiated feeling that employers and educators held widely differing views about the importance of functions of the clinical nurse specialist. The results bore out this feeling although one needs to keep in mind that the nature of the t-test is such that small

differences can become significant when a large sample is used. Because of this, the practical implications of these differences cannot be determined. However, since the probabilities are so low (below p = .000) on 25 of the 30 items which exhibited significance at below the p = .01 level, real differences in these levels of valuation are very likely. The practical differences may be in the tendency of educators to give almost all functions higher levels of importance than employers. Since the lists of the 10 most highly valued functions and least valued functions were so similar for educators and employers, it appeared that they viewed the same functions as most important or least important. This finding has implications for nursing because it discredits a part of the folklore of nursing which holds that nursing service administrators and nursing educators differ radically in their views of how all levels of nurses should be taught to function. From these data, it appears that the differences may be more in rhetoric than in substance. The educators are perhaps more evangelistic in their statements of levels of importance than employers. However, the educators and employers have considerable agreement on the significant issue of which functions rank highest and lowest in importance. In addition, the particular functions ranked as most and least important should give both educators and employers a better idea of whether

their individual expectations are similar to the mainstream of their groups. This comparison could act as a basis for reevaluation of views.

The ranking of the four components of the role of the clinical nurse specialist by educators and employers was not unanticipated. Both groups gave the clinical component the highest ranking. This could be expected in view of the definitions of the role (Scope of Nursing, 1976). The employers ranked the education component second. This expectation of employers for the clinical nurse specialist to give priority to educational functions second only to clinical functions should be addressed by educators. Sufficient emphasis upon educational skills should be included in the preparation of clinical nurse specialists. Educators valued the research component second only to the clinical component. Again, this is not surprising, however this demonstration of the educators' priority for research could be an impetus to employers to attempt to utilize the research skills learned by most clinical nurse specialists. The administration component was given lowest priority by both groups. This low priority was reflected in the literature on the clinical nurse specialist written by educators, employers and practitioners. However, in the job descriptions of clinical nurse specialists reviewed for this investigation, administrative duties were much

more visible. Exployers should review their job descriptions to determine if they really reflect their expectations.

Overall, these findings support some current thinking in nursing and call into question other ideas. The findings are general in nature but can be used as basis for the examination of personal ideas and beliefs of educators and employers of clinical nurse specialists. In addition, they can be used in the evaluation process for educational programs for clinical nurse specialists. Specific recommendation are addressed in the next section.

Recommendations

1. Educators of clinical nurse specialists should review the perceptions of the employers to determine if their respective educational programs prepare the graduates to fulfill expectations of employers.

2. Educators should review their respective programs to see if their programs prepare the clinical nurse specialist graduates to fulfill the educators' expectations.

3. Employers should review the perceptions of the educators and the actual preparation provided in masters' programs for the clinical nurse specialist to determine if they are providing opportunities for their clinical nurse specialist employees to fulfill their potential to

improve patient care.

4. An ongoing dialogue between educators and employers of clinical nurse specialists should be undertaken to facilitate necessary changes in the education and job expectations of clinical nurse specialists to allow full utilization of knowledge and skills to improve patient care.

5. Further study of this area should be undertaken. Specifically, periodic replications of this study should be undertaken to provide information in regard to changing perceptions. In addition, practicing clinical nurse specialists should be surveyed using the CNSFI to determine their perceptions of importance of the functions included and to determine any additional important functions as they develop.

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Appendix A

Representative Job Description for Clinical Nurse Specialists

FUNCTIONS TAKEN FROM 14 JOB DESCRIPTIONS
IDENTIFIED AS PRIMARILY CLINICAL POSITIONS

I. Functions Relating to Personal Development

Ability to communicate effectively by both oral and written methods.

Ability to understand and follow complex oral and written instructions in detail.

Knowledge and skills in group dynamics, process and facilitation.

Leadership ability.

Ability to establish and maintain effective working relationships with patients, physicians, subordinates, peers and with the public.

Participates in professional and community organizations to promote personal and professional growth and development.
(+ 1 related statement)

Contributes to the advancement of nursing practice in his/her setting and the community through participation in educational programs, research, and publication.

Evaluates one's own educational needs for clinical competence and focuses on self-development through either formal or infqrmal programs of continued learning.
(+ 4 related statements)

II. Functions Relating to Clinical Nursing Experiences

Demonstrates the role of the nurse specialist in the health care team.

Identifies problems - establishes a nursing diagnosis.

Identifies long and short term goals.

Plans care; prescribes nursing intervention.

Administers direct patient care.

Initiates and implements health teaching based on nursing assessment.

Assesses and promotes upgrading of nursing care.

Development of tools to assist staff in assessing and providing of patient care; i.e., nursing history form, interview guides.
(+ 106 statements which referred to the above functions)

Serves as a consultant for nursing and medical staff.

Works with other departments and disciplines to coordinate the treatment program.
(+ 16 other statements re: collaboration)

Identifies patient and family education needs. Participates in providing written guides for the staff.
(+ 8 related statements)

The nurse will participate in inservice education for other health personnel.
(+ 28 related statements)

III. Functions Relating to Nursing Education Learning Experiences

Teaching ability.

Identifies components of the nursing process and provides necessary teaching and guidance.

May assist with teaching nursing and allied health students.
(+ 6 related statements)

Serves as a role model for the nursing students assigned to the unit.
(+ 1 related statement)

IV. Functions Relating to Nursing Administration Learning Experiences

Participates in departmental and interdisciplinary committees which influence or

determine policies affecting nursing practice.
(+ 5 related statements)

Participates in defining, maintaining and interpreting standards of nursing practice.
(+ 5 related statements)

Participates in work evaluation of personnel.
(+ 2 related statements)

The responsibility of all nursing activities in an assigned unit(s).
(+ 1 related statement)

Considerable knowledge of professional nursing practice management philosophy and techniques.
(+ 1 related statement)

Interviews and makes recommendations to the Unit Manager and physician superior for hiring Senior Clinical Nurses.

Participates in the development and maintenance of a system of peer review for nursing personnel.

Assists in helping the nursing department meet external standards (J.C.H.A., A.N.A. psychiatric nursing standards and N.L.N. accreditation standards).

Participates in evaluating conditions, resources, and policies essential to delivery of nursing care services.

Reports on administrative matters to the director of the Department of Patient Care and the director of Physical Medicine and Rehabilitation.

Recommends to the Unit Manager and physician superior decisions regarding necessary disciplinary action for Senior Clinical Nurse, and assists in the resolution of complaints or grievances of Senior Clinical Nurses.

Is alert to changing needs on the section, provides direction and helps effect change.

Participation at selected Head Nurse Meetings and Total Administrative Staff Meeting.

Coordinates with the supervisors of the clinical services in requesting equipment.

V. Functions related to learning experiences which emphasize basic research skills

1. "Assesses the needs for significant nursing research in assigned areas of clinical responsibility

   A. Identifies relevant clinical questions appropriate for systematic study.

   B. Assists nursing personnel and members of other services and disciplines in determining research needs influencing health care delivery.

   C. Determines attitudes of critical thinking and inquiry among professional nurses.

2. Plans nursing studies according to accepted nursing research standards

   A. Collaborates with other clinical nurse specialists in designing nursing research studies.

   B. Utilizes resources within and outside when planning research activities.

   C. Assists professional nurses in planning appropriate research projects.

3. Conducts appropriate research related to the practice of nursing

   A. Preserves the individual, human rights of research subjects according to the ANA Guidelines of Ethical Values: The Nurse in Research.

   B. Elicits the participation of nursing personnel and other appropriate persons in implementing planned research methodologies.

   C. Utilizes resources for analysis of research data.

4. Evaluates the processes and results of planned nursing research

   A. Interprets to nursing personnel research data, conclusions, and implications for further study.

B. Assists nursing personnel in critiquing research studies and utilizing findings in implementing change.

C. Communicates results of individual and/or collective research efforts through educational programs, professional meetings, publications, etc.

D. Bases planned change in nursing policies and procedures on the results of appropriate, significant nursing research.

E. Refines research methodologies to improve nursing research processes and outcomes."*
(+ 3 other job descriptions had research statements)

VI. Miscellaneous

May provide consultation for community organization and facilities.
(+ 3 related statements)

Community education

Nursing home

Assertive training groups (community)

In-service training and workshops for nursing and personnel

In-service training nurses at hospital

Community workshops, such as participation in seminar on "Sudden Infant Death Syndrome."

*Taken from the Veterans Administration job description for clinical nurse specialists.

Appendix B

Clinical Nurse Specialist Inventory for Educators

CLINICAL NURSE SPECIALIST FUNCTIONS INVENTORY FOR EDUCATORS
Biographical and Institutional Information

First we would like to ask you about the nursing master's program in which you are employed.

Q-1 For the purposes of this study, the clinical nurse specialist is defined as "a practitioner holding a master's degree with a concentration in specific areas of clinical nursing. The role of the clinical nurse specialist is defined by the needs of a select client population, the expectations of the larger society, and the clinical expertise of the nurse. By exercising judgement and demonstrating leadership ability, the clinical-nurse specialist functions within a field of practice that focuses on the needs of /the/ client system and encompasses interaction with others in the nursing and health care systems serving the client. . . ." (American Nurses Association, 1976)

For which clinical areas does your school prepare clinical nurse specialists? (Circle as many as apply.)

1 Medical Surgical Nursing
2 Pediatric Nursing
3 Maternity Nursing
4 Mental Health Nursing
5 Community Health Nursing
6 Other (please specify _____)

Q-2 How many clinical nurse specialists graduate from your program each year?

1 Fewer than 10 graduates
2 10-25 graduates
3 More than 25 graduates

Q-3 What is the total enrollment of your master's program?

1 Fewer than 100
2 100-250
3 More than 250

Next we would like to ask you about yourself. Please circle the number of the appropriate phrase.

Q-4 In which clinical area do you teach? (Circle as many as apply.)

1 Medical Surgical Nursing
2 Pediatric Nursing
3 Maternity Nursing
4 Mental Health Nursing
5 Community Health Nursing
6 Other (please specify _____)
7 I do not teach in a clinical area.

Q-5 In which functional area do you teach?

1 Education
2 Administration
3 Research
4 Other (please specify _____)
5 I do not teach in a functional area.

Q-6 What academic rank do you hold?

1 Professor
2 Associate Professor
3 Assistant Professor
4 Instructor
5 Other (please specify _____)

Q-7 How long have you been teaching graduate students in nursing?

1 Less than 1 year
2 1-5 years
3 6-10 years
4 Longer than 10 years

Q-8 What is your academic background? (Please circle as many as apply.)

1 Associate Degree in Nursing
2 Diploma in Nursing
3 Bachelor of Science in Nursing
4 Bachelor's Degree in Non-nursing Area
5 Master's Degree in Nursing
6 Master's Degree in Non-nursing Area
7 Doctor's Degree in Nursing
8 Doctor's Degree in Non-nursing Area

Q-9 What was the year in which your last formal diploma or degree was granted? _____ (Please indicate year on line provided.)

Q-10 In which group of states is your school located?

1 Kansas, Nebraska, Missouri, Oklahoma
2 Iowa, Illinois, Indiana, Ohio
3 Minnesota, Wisconsin, Michigan

PLEASE PROCEED TO THE CLINICAL NURSE SPECIALIST FUNCTIONS INVENTORY

CLINICAL NURSE SPECIALIST FUNCTIONS INVENTORY

This scale is developed to determine how educators of master's students in nursing view the relative importance of specific functions expected of the clinical nurse specialist in the hospital or community employment setting.

Instructions

Please circle the number which indicates your perception of the importance of each function in the job of a clinical nurse specialist (CNS). Please base your answer upon your perception of the importance you, as a teacher, place on each function as you prepare the student for the CNS role.

Please use the following scale:

0 Not expected in position
1 Slightly important
2 Important
3 Very important
4 Utmost importance

0	1	2	3	4	Q-1	Assesses patient problems.
0	1	2	3	4	Q-2	Establishes a nursing diagnosis.
0	1	2	3	4	Q-3	Establishes long and short term goals for care of individual patients.
0	1	2	3	4	Q-4	Prescribes nursing interventions.
0	1	2	3	4	Q-5	Administers routine direct patient care.
0	1	2	3	4	Q-6	Administers specialized direct patient care.
0	1	2	3	4	Q-7	Initiates health teaching to be done by other nursing personnel for patients and families based on nursing assessment.
0	1	2	3	4	Q-8	Implements health teaching for patients and families based on nursing assessment.
0	1	2	3	4	Q-9	Assesses quality of nursing care in specific area.
0	1	2	3	4	Q-10	Promotes upgrading of nursing care in specific area.
0	1	2	3	4	Q-11	Coordinates patient care with other disciplines or departments.
0	1	2	3	4	Q-12	Develops assessment and evaluation tools to assist staff in planning and providing patient care.
0	1	2	3	4	Q-13	Acts as consultant for nursing staff.
0	1	2	3	4	Q-14	Acts as consultant for medical staff.
0	1	2	3	4	Q-15	Provides assistance to nursing staff in meeting identified patient and family health education needs.
0	1	2	3	4	Q-16	Participates in formal and informal inservice education for non-nursing health personnel.
0	1	2	3	4	Q-17	Participates in formal and informal inservice education for nursing personnel.
0	1	2	3	4	Q-18	Serves as a role model for nursing students.
0	1	2	3	4	Q-19	Assists with clinical and theoretical teaching of nursing students.
0	1	2	3	4	Q-20	Contributes to the education of the public through participation in health oriented organization programs and/or membership activities.
0	1	2	3	4	Q-21	Participates in institutional committees which influence or determine policies affecting nursing practice.
0	1	2	3	4	Q-22	Takes leadership in defining, maintaining and interpreting standards of nursing practice.
0	1	2	3	4	Q-23	Participates in formal evaluation of nursing personnel.
0	1	2	3	4	Q-24	Has responsibility for all nursing activities in a clinical area.
0	1	2	3	4	Q-25	Participates in decisions regarding employment of nursing personnel.
0	1	2	3	4	Q-26	Participates in decisions regarding termination of nursing personnel.
0	1	2	3	4	Q-27	Takes leadership in the development and maintenance of a system of peer review for nursing personnel.
0	1	2	3	4	Q-28	Participates in evaluating conditions, resources, and policies essential to the delivery of nursing care service.
0	1	2	3	4	Q-29	Monitors changing needs of clinical area and institutes appropriate change.
0	1	2	3	4	Q-30	Assesses the needs for nursing research in clinical area.
0	1	2	3	4	Q-31	Identifies relevant clinical questions appropriate for systematic study.
0	1	2	3	4	Q-32	Plans nursing studies according to accepted nursing research standards.
0	1	2	3	4	Q-33	Conducts research relating to nursing practice.
0	1	2	3	4	Q-34	Evaluates the nursing research process.
0	1	2	3	4	Q-35	Interprets to nursing personnel the results of nursing research.
0	1	2	3	4	Q-36	Assists nursing personnel in utilizing research to effect change.
0	1	2	3	4	Q-37	Communicates results of research through presentations and publications.

Appendix C

Clinical Nurse Specialist Inventory for Employers

CLINICAL NURSE SPECIALIST FUNCTIONS INVENTORY FOR EMPLOYERS
Biographical and Institutional Information

First we want to ask you about the clinical nurse specialists employed by your agency.

Q-1 For the purposes of this study, the clinical nurse specialist is defined as "a practitioner holding a master's degree with a concentration in specific areas of clinical nursing. The role of the clinical nurse specialist is defined by the needs of a select client population, the expectations of the larger society, and the clinical expertise of the nurse. By exercising judgement and demonstrating leadership ability, the clinical nurse specialist functions within a field of practice that focuses on the needs of /the/ client system and encompasses interaction with others in the nursing and health care systems serving the client. . . ." (American Nurses Association, 1976)

Does your agency currently employ clinical nurse specialists?

1 Yes; if yes, proceed to Question 2.
2 No; if no, do not proceed. Please write the name of your institution and city in the spaces and return this questionaire in the envelope provided. It is important that we know which agencies do not employ clinical nurse specialists so that we may remove them from our lists. _____ _____

Q-2 How many clinical nurse specialists does your agency currently employ in each of the following clinical areas? Please indicate number on the line provided.

_____ Medical Surgical Nursing
_____ Pediatric Nursing
_____ Maternity Nursing
_____ Mental Health Nursing
_____ Community Health Nursing
_____ Other (please specify _____)

Q-3 How many years ago did your agency first hire a clinical nurse specialist?

1 Less than 1 year ago
2 1-5 years ago
3 6-10 years ago
4 Over 10 years ago

Next we want to ask you about yourself and your health agency. Please circle the number of the phrase which best describes you.

Q-4 Which of the following titles best describes your position?

1 Director of Nursing Service
2 Associate or Assistant Director of Nursing Service
3 Supervisor or Care Coordinator of _____ Service
4 Director of Personnel
5 Other (please specify _____)

Q-5 How long have you held the position indicated above?

1 Less than 1 year
2 1-5 years
3 6-10 years
4 Longer than 10 years

Q-6 What is your academic background? (Please circle as many as apply.)

1 Associate Degree in Nursing
2 Diploma in Nursing
3 Bachelor of Science in Nursing
4 Bachelor's Degree in Non-nursing Area
5 Master's Degree in Nursing
6 Master's Degree in Non-nursing Area
7 Doctor's Degree in Nursing
8 Doctor's Degree in Non-nursing Area

Q-7 What was the year in which your last formal diploma or degree was granted? _____

Please circle the number of the phrase which best describes your institution or agency.

Q-8 What kind of agency employs you?

1 A private community hospital
2 A public hospital
3 A community health outpatient agency
4 A community mental health center
5 A special services agency dealing with a specialized clientele. If so, what kind of patients?
_____
6 Other (please specify _____)

Q-9 If it is a hospital, what is its bed capacity?

1 200-400
2 401-800
3 More than 800
4 Non-applicable

Q-10 If it is a community health outpatient agency or mental health center, what is its yearly case load?

1 Fewer than 100
2 101-500
3 501-1000
4 More than 1000
5 Non-applicable

Q-11 In which group of states is your agency located?

1 Kansas, Nebraska, Missouri, Oklahoma
2 Iowa, Illinois, Indiana, Ohio
3 Minnesota, Wisconsin, Michigan

PLEASE PROCEED TO THE CLINICAL NURSE SPECIALIST FUNCTIONS INVENTORY

CLINICAL NURSE SPECIALIST FUNCTIONS INVENTORY

This scale is developed to determine how employers view the relative importance of specific functions of the clinical nurse specialist in the hospital or community health setting.

Instructions

Please circle the number which indicates your perception of the importance of each function in the job of a clinical nurse specialist (CNS) in your institution. Your answer should be based upon your perception of the importance of each function in the actual CNS positions in your institution, not on the general capabilities which you might associate with the clinical nurse specialist.

Please use the following scale:

0 Not expected in position
1 Slightly important
2 Important
3 Very important
4 Utmost importance

0 1 2 3 4	Q-1	Assesses patient problems.
0 1 2 3 4	Q-2	Establishes a nursing diagnosis.
0 1 2 3 4	Q-3	Establishes long and short term goals for care of individual patients.
0 1 2 3 4	Q-4	Prescribes nursing interventions.
0 1 2 3 4	Q-5	Administers routine direct patient care.
0 1 2 3 4	Q-6	Administers specialized direct patient care.
0 1 2 3 4	Q-7	Initiates health teaching to be done by other nursing personnel for patients and families based on nursing assessment.
0 1 2 3 4	Q-8	Implements health teaching for patients and families based on nursing assessment.
0 1 2 3 4	Q-9	Assesses quality of nursing care in specific area.
0 1 2 3 4	Q-10	Promotes upgrading of nursing care in specific area.
0 1 2 3 4	Q-11	Coordinates patient care with other disciplines or departments.
0 1 2 3 4	Q-12	Develops assessment and evaluation tools to assist staff in planning and providing patient care.
0 1 2 3 4	Q-13	Acts as consultant for nursing staff.
0 1 2 3 4	Q-14	Acts as consultant for medical staff.
0 1 2 3 4	Q-15	Provides assistance to nursing staff in meeting identified patient and family health education needs.
0 1 2 3 4	Q-16	Participates in formal and informal inservice education for non-nursing health personnel.
0 1 2 3 4	Q-17	Participates in formal and informal inservice education for nursing personnel.
0 1 2 3 4	Q-18	Serves as a role model for nursing students.
0 1 2 3 4	Q-19	Assists with clinical and theoretical teaching of nursing students.
0 1 2 3 4	Q-20	Contributes to the education of the public through participation in health oriented organization programs and/or membership activities.
0 1 2 3 4	Q-21	Participates in institutional committees which influence or determine policies affecting nursing practice.
0 1 2 3 4	Q-22	Takes leadership in defining, maintaining and interpreting standards of nursing practice.
0 1 2 3 4	Q-23	Participates in formal evaluation of nursing personnel.
0 1 2 3 4	Q-24	Has responsibility for all nursing activities in a clinical area.
0 1 2 3 4	Q-25	Participates in decisions regarding employment of nursing personnel.
0 1 2 3 4	Q-26	Participates in decisions regarding termination of nursing personnel.
0 1 2 3 4	Q-27	Takes leadership in the development and maintenance of a system of peer review for nursing personnel.
0 1 2 3 4	Q-28	Participates in evaluating conditions, resources, and policies essential to the delivery of nursing care service.
0 1 2 3 4	Q-29	Monitors changing needs of clinical area and institutes appropriate change.
0 1 2 3 4	Q-30	Assesses the needs for nursing research in clinical area.
0 1 2 3 4	Q-31	Identifies relevant clinical questions appropriate for systematic study.
0 1 2 3 4	Q-32	Plans nursing studies according to accepted nursing research standards.
0 1 2 3 4	Q-33	Conducts research relating to nursing practice.
0 1 2 3 4	Q-34	Evaluates the nursing research process.
0 1 2 3 4	Q-35	Interprets to nursing personnel the results of nursing research.
0 1 2 3 4	Q-36	Assists nursing personnel in utilizing research to effect change.
0 1 2 3 4	Q-37	Communicates results of research through presentations and publications.

Appendix D

Letter to Clinical Nurse Specialists for Validation of Inventory

THE UNIVERSITY OF KANSAS

School of Nursing
College of Health Sciences
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1601

Dear:

I am in the process of developing a questionnaire which can be used to assess the perceptions of employers and educators as to the relative importance of specific functions of clinical nurse specialists. I have developed the instrument from the literature, job descriptions for clinical nurse specialists and conversations with clinical nurse specialists.

I'm now at the point where I need feedback on a draft of the questio nnaire from clinical nurse specialists themselves so that I may determine whether I have included all functions of the clinical nurse specialist. Therefore, I am writing to ask your help. Your name has been suggested to me as a nurse who either is functioning or has functioned as a clinical nurse specialist. I would certainly appreciate it if you would take the time to respond to the questionnaire from the point of view of your perception of the importance of each function, and to record any other functions which I have omitted. In addition, I would appreciate any criticisms or suggestions you might have in regard to format or wording of any of the items.

You will notice that I have made little or no distinction regarding depth of knowledge or level of expertise in the statement of each function. This distinction is made clear in the definition of clinical nurse specialist which I will use in introducing the questionnaire (American Nurses Association, 1976). In addition, this questionnaire is not intended to be used in any attempt at differentiating levels of practice.

I am very grateful for your help. This instrument will be used in my dissertation and in the ongoing evaluation project of the Master in Nursing Program at the University of Kansas. I am enclosing a stamped, self-addressed envelope for your convenience. If you have any questions, please feel free to contact me by phone (588-1614) or by mail.

Sincerely,

Rita Clifford

Rita Clifford, R.N., M.S.
Doctoral Candidate
University of Kansas

Appendix E

Letter to Deans of Schools of Nursing

THE UNIVERSITY OF KANSAS

School of Nursing
College of Health Sciences
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1601

July 16, 1980

Dear :

I am writing to ask your help in a study which is part of an ongoing evaluation project of the Masters Program in Nursing at the University of Kansas and is my dissertation. This study could also have implication for evaluations of masters programs in the midwest region.

The purpose of the study is to determine if educators and employers of clinical nurse specialists (CNS) in 11 midwestern states which have NLN accredited masters programs in nursing hold similar or different perceptions of the importance of specific job functions of the clinical nurse specialist.

When this study was planned, I intended to use the graduate faculty lists from the Midwest Directory of Resources for Graduate Education for Nursing for my population of educators. Currently the data base contains only doctorally prepared graduate nursing faculty for schools in this region. I would prefer to use lists which contain all nursing graduate faculty in order to provide a broader basis for my sample. The only way for me to obtain this is through the cooperation of the administrators of the schools of nursing in the midwest region. Would you share the names of the graduate nursing faculty in your school with me? I give you my assurance that the list of graduate faculty you send to me will be used only for sampling purposes. I will not allow any use of the list other than for my sampling purposes and will destroy the list when the process is complete or return it to you, whichever you prefer.

I hope that you will agree to assist me. If I can sample from the entire population of graduate nursing faculty in the Midwest, my results will be more likely to be representative of the perceptions of graduate nursing educators of clinical nurse specialists in the Midwest.

If you have any questions about the study, you may contact me or Dr. Margery Duffey, the Director of Graduate Programs at (913) 588-1614. Thank you for your assistance.

Sincerely,

Rita Clifford

Rita Clifford, R.N., M.S.
Associate Professor
Director of Graduate Student Affairs

RC/cb

Appendix F

Letters to Potential Employers

THE UNIVERSITY OF KANSAS

School of Nursing
College of Health Sciences
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1601

May 23, 1980

I am writing to ask your help in a project which could have implications for evaluations of master's programs in nursing in the midwest region. This study is a part of an evaluation project for the University of Kansas School of Nursing Master's Program and is my dissertation.

The purpose of this study is to determine if educators and employers of clinical nurse specialists (CNS) in the midwestern states which have NLN-accredited master's programs hold similar or different perceptions of the importance of specific job functions of the clinical nurse specialist. The enclosed Clinical Nurse Specialist Functions Scale has been developed to allow educators and employers to indicate their perception of the importance of each function in the job setting.

Your institution has been randomly selected from the American Hospital Association's Directory or from lists of community health agencies in each state. If your institution does not employ nurses with clinical nurse specialist preparation, please write your institution or agency name and city in question one on the questionaire and return it to me in the enclosed envelope. Do not return the post card. Your participation, while strictly voluntary, is important to maintain the integrity of the sample. Your perceptions, as an employer, are crucial to the purpose of the study and your participation will aid in the results being more likely to be representative of employers of the CNS in the Midwest.

The questionaire requires approximately 15 minutes to complete. After completion of the questionaire, please seal it in the enclosed stamped self-addressed envelope. Then place your name, address and institution name on the enclosed post card and mail both the envelope and the post card. This procedure allows me to determine who has returned the questionaires while guaranteeing complete anonymity to the respondents. Return of the completed questionaire signals your consent to participate.

I thank you for your help. If you have any comments or questions regarding the study, please feel free to write them on the questionaire, write me at this address or call me at 913/588-1614. Please return the questionaire by June 13, 1980.

Sincerely,

Rita Clifford

Rita Clifford, R.N., M.S.
School of Nursing
University of Kansas

THE UNIVERSITY OF KANSAS

School of Nursing
College of Health Sciences
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1601

October 13, 1980

Dear Director of Clinical Services:

I am writing to ask your help in a project which could have implications for evaluations of master's programs in nursing in the midwest region. This study is a part of an evaluation project for the University of Kansas School of Nursing Master's Program and is my dissertation.

The purpose of this study is to determine if educators and employers of clinical nurse specialists (CNS) in the midwestern states which have NLN-accredited master's programs hold similar or different perceptions of the importance of specific job functions of the clinical nurse specialist. The enclosed Clinical Nurse Specialist Functions Scale has been developed to allow educators and employers to indicate their perception of the importance of each function in the job setting.

Your institution has been randomly selected from the American Hospital Association's Directory or from lists of community health agencies in each state. If your institution does not employ nurses with clinical nurse specialist preparation, please write your institution or agency name and city in question one on the questionaire and return it to me in the enclosed envelope. Please return the unused post card. Your participation, while strictly voluntary, is important to maintain the integrity of the sample. Your perceptions, as an employer, are crucial to the purpose of the study and your participation will aid in the results being more likely to be representative of employers of the CNS in the Midwest.

The questionaire requires approximately 15 minutes to complete. After completion of the questionaire, please seal it in the enclosed stamped self-addressed envelope. Then place your name, address and institution name on the enclosed post card and mail both the envelope and the post card. This procedure allows me to determine who has returned the questionaires while guaranteeing complete anonymity to the respondents. Return of the completed questionaire signals your consent to participate.

I thank you for your help. If you have any comments or questions regarding the study, please feel free to write them on the questionaire, write me at this address or call me at 913/588-1614. Please return the questionaire by October 20, 1980.

Sincerely,

Rita Clifford

Rita Clifford, R.N., M.S.
School of Nursing
University of Kansas

THE UNIVERSITY OF KANSAS

School of Nursing
College of Health Sciences
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1601

October 13, 1980

To: Director of Clinical Services

From: Rita Clifford, Associate Professor
School of Nursing

Several weeks ago, you received a letter (see copy attached) requesting your participation in a study of employer expectations of clinical nurse specialists (CNS).

We have had a very good response to our request. Seventy-four percent of those contacted have replied. We have not yet heard from you. We would like to be able to include your views in the results of the study. Won't you please read the attached letter and help us by letting us know if you do not hire clinical nurse specialists or by completing the survey form if you do hire CNS. The instructions for responding are included in the letter.

Thank you very much for your help!

RC/cb
Enclosures

THE UNIVERSITY OF KANSAS

School of Nursing
College of Health Sciences
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1601

October 1, 1980

To: Directors of Nursing Service

From: Rita Clifford, Associate Professor
School of Nursing

Several weeks ago, you received a letter (see copy attached) requesting your participation in a study of employer expectations of clinical nurse specialists (CNS).

We have had a very good response to our request. Seventy-four percent of those contacted have replied. We have not yet heard from you. We would like to be able to include your views in the results of the study. Won't you please read the attached letter and help us by letting us know if you do not hire clinical nurse specialists or by completing the survey form if you do hire CNS. The instructions for responding are included in the letter.

Thank you very much for your help!

RC/cb
Enclosures

Appendix G

Letters to Educators

THE UNIVERSITY OF KANSAS

School of Nursing
College of Health Sciences
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1601

September 25, 1980

Dear:

I am writing to ask your help in a project which could have implications for evaluations of master's programs in nursing in the Midwest region. This study is a part of an evaluation project for the University of Kansas School of Nursing Master's Program and is my dissertation.

The purpose of this study is to determine if educators and employers of clinical nurse specialists (CNS) in the Midwestern states which have NLN-accredited master's programs hold similar or different perceptions of the importance of specific job functions of the clinical nurse specialist. The enclosed Clinical Nurse Specialist Functions Inventory has been developed to allow educators and employers to indicate their perception of the importance of each function in the job setting.

Your name has been randomly selected from lists of graduate nursing faculty obtained from nursing master's programs in the region. Your perceptions, as an educator, are crucial to the purpose of the study. Your participation, while strictly voluntary, is very important to maintain the integrity of the sample. If all persons selected choose to participate, the results will be more likely to be representative of all educators and employers of the clinical nurse specialists in the Midwest.

The questionnaire requires approximately 15 minutes to complete. After completion of the questionnaire, please seal it in the enclosed stamped self-addressed envelope. Then place your name, address and institution name on the enclosed post card and mail both the envelope and the post card. This procedure allows me to determine who has returned the questionnaire while guaranteeing complete anonymity to the respondents. Return of the completed questionnaire signals your consent to participate.

I thank you for your help. If you have any comments or questions regarding the study, please feel free to write them on the questionnaire, write me at this address or call me at 913/588-1614. Please return the questionnaire by October 16.

Sincerely,

Rita Clifford

Rita Clifford, R.N., M.S.
School of Nursing
University of Kansas

RC/cb
Enclosures

THE UNIVERSITY OF KANSAS

School of Nursing
College of Health Sciences
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1601

November 6, 1980

To: Graduate Nursing Faculty

From: Rita Clifford, Associate Professor
School of Nursing

Several weeks ago, you received a letter (see copy attached) requesting your participation in a study of educator expectations of clinical nurse specialists (CNS).

We have had a very good response to our request. Seventy-six percent of those contacted have replied. We have not yet heard from you. We would like to be able to include your views in the results of the study. Won't you please read the attached letter and help us by completing the survey form. The instructions for responding are included in the letter.

Thank you very much for your help!

RC/cb
Enclosures